

Municipal public health planning needs representational skills within the community

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Abstract

Municipal public health planning (MPHP) endeavours to enhance community participation in public health decision making. A study of community participation of municipal public health planning projects in Queensland, Australia highlights that while community participation is an important element of the planning, the focus is also on developing mechanisms to ensure intersectoral collaborations and placing public health issues on the agenda of decision makers. With modest funding and the breadth of these focuses, MPHP is limited in directly supporting disadvantaged groups in the community to engage in participatory activities. The challenge can be to engage all the relative perspectives of the community, particularly if it is typical of a group to demonstrate non-participation in whole of community group activities. Success in the area of engaging with target groups was found by having the time and project staff to identify and access an advocate or advocacy forum to represent a voice for the group. This highlights the importance of representative and advocacy roles in the community.

Key words: public health, community participation, community advocacy, health planning, municipal

Introduction

The Queensland framework of Municipal Public Health Planning (MPHP) is based on the WHO Healthy Cities model. The WHO Healthy Cities global movement endeavours to 'promote comprehensive and systematic policy and planning for health'. It also aims to address inequality in health and urban poverty; the needs of vulnerable groups; participatory governance; and the social, economic and environmental determinants of health (WHO, www.euro.who.int, 2011). This emphasis resonates with the Australian government's vision of a socially inclusive society 'one in which all Australians feel valued and have the opportunity to participate fully in the life of society' (www.socialinclusion.gov.au, 2011). Which they

go to outline includes to resources, opportunities and capability to 'have a voice so that they can influence decisions that affect them'.

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).

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 on governments to be more responsive to inequalities. The contemporary debate is not about whether or not community participation is important; rather, it concerns the different interpretations of the nature of participation and its ideal forms or levels. Consequently research has been undertaken to further understand and learn from the community participation occurring in MPHP projects in Queensland.

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 the 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 warns against the tradition of 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) suggests 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).

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 was a qualitative study involving an in-depth investigation of the perceptions and experience of participants involved in local level public health planning.

Methodology

This work emerges from a doctoral study exploring community participation in MPHP in Queensland. 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.

This research adopted a 'bounded system' case study approach (Liampputtong, 2009). The outcomes of exploring bounded system/s are reports on case descriptions and case based themes (Creswell, 2007 cited by Liampputtong, 2009, p. 191). The use of the MPHP model thus provided a boundary for this 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. Case studies are noted to be useful when looking at real - life context is considered important (Yin, 2003, p. 1).

The key stakeholder interviews were also an important methodology used to explore interviewees, with experience of real life MPHP, understanding and opinions on the meaning of community participation and particularly in a MPHP process. A stakeholder analysis identified the categories of stakeholders in the MPHP projects as: elected representatives; local project managers, project officers, local government staff, state health staff employed in health promotion and environmental health roles, community members or members of non-government organizations, and others (others included non-health state government staff and also federal government staff).

The interviews had a semi-structured format. To ensure interviews achieve a conversation within which the research goal is not lost interview guides or schedules, which vary from list of topics to be covered to exact questions, are used (Ruane, 2005). Prior to the conducting of interviews, a literature review had been conducted to establish a conceptual framework for developing a functional meaning of community participation for MPHP practitioners. This 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. Consequently an interview guide was developed to encourage conversations around these topics. Grounded theory was used to analysis participants' responses. 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. In this study interview transcripts were studied and emerging points coded which were then grouped for further analysis of themes and subthemes.

Ethics approval was sort and obtained from the Griffith University Human research ethics committee for this research.

Purposive sampling was used with 8-12 stakeholders from three MPHP projects, conducted in Southeast and central Queensland, asked to be involved in interviews. First contact was made by either the researcher or a local project officer who passed willing participant details onto the researcher. During the first contact the researcher had with potential participants they were informed of the nature of the research, the cooperation being asked for and the principles of informed consent and confidentiality. If participants indicated a willingness to be involved dates and times to meet were set up. A total of 33 agreed to participate in interviews with a good distribution across the projects (10 involved from one, 11 another and 12 another).

Results

Bracht and Tsouros (1990) and Rifkin (1990) have proposed that defining community participation requires establishing the specific who, what and how concepts of the given participation. In support of this when stakeholders were asked an open question about their understanding of community participation, this study found that it was instinctive to consider who should be involved, what form this involvement should take and what was needed to achieve this definition of who and what. Within MPHP 'who' implied allowing everyone an opportunity to 'have a voice', and of seeking broad representation. The need to have a structured process to accomplish decision-making was also highlighted. Community participation in MPHP that emerged was 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 an opinion. The data also reveals that a process for achieving community participation in MPHP requires two key characteristics: seeking broad representation, and of being a structured process which feeds a community voice to decision makers for consideration.

Consequently the study found that what community participation means to those involved in MPHP is: something that everyone is eligible to be involved in; involves a broad approach to the seeking of representation from the community; is the act of having a 'voice'; and requires a structure process for these 'voices' to influence decision making:-

Everyone is eligible to be a participant: the interviewees felt that community participation means inclusive involvement practices, 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, they also feel it is important to approach different elements of the community to be involved. As demonstrated by the following informant comment, 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)

Act of having a say: reference was 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 input into the discussion of needs as well as 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', projected 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)

Needs a process: for community participation to be really meaningful it is necessary to create a structured process by deciding who provides input and combine this with the act of voicing needs and ideas.

Interviewees considered that community participation requires work to inform people, to identify who to consult, and to gain knowledge on whose role it is to capture the issues arising. 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 outcomes:

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)

Clearly community participation is understood to be a process of involving community into decision-making and achieving outcomes. The structured process is believed to have five 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 indicated 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.

Another key area covered in the stakeholder interviews was 'who' can be involved in MPHP. 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, for a variety of reasons, do not. 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 categories concerning 'who' should be involved in local MPHP emerged: 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.

The first category emerging for who should be involved in MPHP is 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 do so. This is illustrated in the following quote from the key informant interviews.

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

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 in the issuing of the invitation.

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)

This study finds that it is preferable that MPHP participants should be local residents, 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 individuals 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)

This not only highlights that people within a region can have local's best interests, it also shows the respect that was given to the role that advocates or representatives working with groups can have. This can provide a mechanism for groups to have a voice and ultimately influence decision making.

Discussion

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 rather than one level, in deliberations by those interviewed. The preferred optimum level for both the role of the community and the role of the health planner is of 'joint planning structures' followed by 'active consultation and advice'.

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.

There was much 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 on 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 reflects both pluralist and post structuralist understanding of health development. The pluralist understanding is reflected in terms of the recognition that 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. 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 and the challenge can be to engage all those perspectives. Stakeholders indicated that some had experienced difficulty engaging certain target groups in the process. Success in the area of engaging with target groups, such as

indigenous, elderly, youth or disability groups, was achieved 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. They could ask for opinions on the priorities or issues arising; ask for representation in the project process; and seek support staff or volunteer advocates from particular groups who can support the involvement of a target 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.

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 workplace 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 become 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.

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 based MPHP 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 of each population to channels of power, resources, communication and participation. Key informant interviews suggest the rural community was characterised by having many 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 wellbeing and a shared agenda. In addition the involvement and ownership by local stakeholders and associations allows for wider participation in defining health and wellbeing 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 a chord with what influenced the actual participation in the MPHP projects. Stakeholders in two of the projects noted favourable conditions for MPHP had occurred when the projects occurred at a time when people were seeking to work more together. Coincidentally, the rural MPHP project started at the same time as a media headline labelled them a poor community. This incident is believed to have contributed to a desire to work together to prove this 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 were achieving some success but were being limited in scope generating an underlying desire to be able to develop and strengthen the ability to work together somehow. Again there was a desire to be connected. One of the biggest challenges to the MPHP approach 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 an 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 MPHP 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 because generally a group, agency or organisation inherently gets a greater final say 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 focus of MPHP 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 MPHP 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.

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 perspectives 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 of this empowerment amongst the community, 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 is staff skilled in facilitation, advocating, political networking and capacity building, and where there is organisational and political support.

Conclusion

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.

To influence decision making and effect changes in response to emerging local public health issues, local level or municipal public health planning relies on an ability to form links within the local community as well as vertically to authorities and their decision makers. Thus it can be limited by both political and organisational willingness to enter into partnership decision making, as well as by the community's uptake of opportunities to voice opinions and be part of identifying and addressing public health concerns. MPHP requires a desire within the community to be connected and to work together. However, it cannot be assumed that within communities there is a strong desire to be part of civic collective action and that all parts of the community will feel an obligation or responsibility to add a voice and be part of whole of community action to work on public health concerns. Where this may be most concerning is when it hinders the involvement of a voice from the disadvantaged and those experiencing the most hardship within the community. These pockets of the community may not readily engage in community based group action. It is important to develop a link or 'bridge' between groups in the community and the MPHP process. For vulnerable or isolated groups this may require the encouragement of representational skills from within the group and/or to draw on the advocacy skills of agencies and volunteers who work with these groups.

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