



Chapter 9: Community Development and Empowerment— A Review of Interventions to Improve Aboriginal Health

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Abstract

'[T]he question of where to start addressing social determinants of health in Indigenous settings remains a real issue for practitioners in the field' (Tsey *et al.* 2003). This paper contributes to the development of a research agenda on the social determinants of health by focusing on interventions that have engaged Aboriginal communities in tackling social inequalities. A review of published literature was conducted in order to explore the limits and potential for community development interventions to contribute to improved Aboriginal health. The objectives of the review were to: identify community development interventions to improve and maintain health and wellbeing in Aboriginal settings that have been documented or evaluated; explore and define the theoretical underpinnings of 'community development' as it is described in the literature; describe identified interventions including how community development principles are conceptualised, challenges faced and lessons learned, particularly those relating to factors critical to their success and sustainability; and identify appropriate methodologies for evaluating community development interventions in Aboriginal settings.

Key findings include:

- the mainstream literature describing community development and empowerment interventions to improve health in Aboriginal Australia is extremely limited, particularly in terms of Indigenous perspectives. This may be because community development is generally *done*, rather than theorised, evaluated and written up;
- a small number of studies comprehensively discuss the theory and application of community development approaches and demonstrate that empowerment outcomes and increased control can be fostered using this approach; and,
- key factors critical to the success of community development and empowerment in Aboriginal settings are identified in the available literature.

This suggests that long-term research is required to determine the potential for different community development interventions to contribute to empowerment and improved health outcomes. There is a need to develop appropriate, practical evaluation

methodologies capable of assessing and explaining community development and empowerment processes and outcomes, and how they contribute to improved health.

Social determinants of health and community development theory

The conceptual relationship between social determinants and community development

The complex nature of the social determinants of health and the broad range of interventions labelled 'community development' amplify the need for conceptual clarity about these terms and their relationship, before reviewing the community development literature. Research on 'the social gradient of disease' shows that relative rather than absolute disadvantage is the main cause of health disparity (Marmot 2000; Wilkinson 2002). Exploration of the 'social gradient of disease' suggests that one of the most critical psychosocial factors is 'the control factor', which refers to the amount of control people have over their lives, including whether they are part of an integrated social network and whether they have access to supportive relationships (Syme 1998). Despite the undeniable links between social class and population health disparities, public health interventions that directly address social class as a risk factor are hard to find (Syme 1998). The complexity of class as a social phenomenon, and the notions of social revolution often associated with the concept, are likely contributing factors to public health practitioners preferring to focus their interventions on individual lifestyle risk factors.

Syme (1998) argues that a possible 'solution' lies neither in social revolution nor medicalising social problems for health service intervention. Rather we should focus on aspects of social class that are amenable to change, such as 'control of destiny', and empower individuals and communities to develop the capacity to exert greater control and influence over their social circumstances (Syme 1998, 2004). A key point in Syme's and other similar analyses is that there is no single entry point for tackling health inequalities and that policies and strategies

need to be multilevel and multifaceted, underpinned by long-term research (Oldenburg *et al.* 2000; Syme 2004). In other words, interventions that promote empowerment and control are just one of a raft of approaches that should be implemented as part of an overall strategy to reduce health inequalities.

Specific social determinants of the poor health of Aboriginal Australians include the history of colonisation, poverty, racism, unemployment, lack of education and training, and a lack of access to appropriate health services. Social inequality and relative powerlessness have long been identified as major factors in Aboriginal health and wellbeing (Devitt *et al.* 2001; Scrimgeour 1997). However, there is a chronic lack of knowledge of what can be done to tackle health inequalities experienced by extremely disadvantaged population groups such as Indigenous Australians, and it is difficult to find tested and validated empowerment programs in the Indigenous health literature (Tsey *et al.* 2003). The twin constructs of 'empowerment' and 'control of destiny' have been identified as potentially useful analytical tools for understanding and addressing the social determinants of Indigenous health (Oldenburg *et al.* 2000; Tsey *et al.* 2003). Indigenous leaders also view 'empowerment' initiatives that will assist Indigenous people to take greater control and responsibility for their situation as a possible 'solution' to the ongoing deterioration of many aspects of Indigenous health and wellbeing (Pearson 2000). In particular, Aboriginal community-controlled health services, government departments, and public health practitioners and researchers have identified community development as a useful approach for improving Aboriginal health as it promotes the development of locally appropriate health interventions and fosters individual and community empowerment (Bell 1996; Biven 2000; Feather *et al.* 1993; Ife 2002; THS 1999). Despite the logical connection between the 'control factor' and Indigenous disempowerment, it is less clear how 'control' operates at the individual, group and community level, and in different cultural settings, and how empowerment can best be fostered, including through the use of community development approaches.

In the context of Fourth World Indigenous populations, analysts have been concerned that contemporary measures of social determinants may not be appropriate for the socio-cultural frameworks of health because these measures and indicators have been developed almost entirely in Euro-cultural contexts (Elias 2003). Morrissey (2003) has been critical of the social determinants of health literature in relation to Aboriginal Australians. Some of his key criticisms are: the uncritical application of findings from overseas studies to the

Aboriginal Australian context; its theoretical 'barrenness' or lack of social science theoretical grounding; the dominance of simplistic quantitative positivism that is incapable of capturing the aetiology of chronic diseases; and the failure to centre Aboriginal people as the dominant partners in research involving them (Morrissey 2003). These justified criticisms highlight the need to explore the relationship between community development interventions and empowerment in the Australian Aboriginal setting, the theory and concepts underpinning interventions, and the range of methods used to explore and evaluate such interventions.

Community development concepts

There is a great deal of confusion and contention in the literature about the term 'community development' and its constituent concepts of 'community', 'participation', 'involvement', 'power', 'capacity' and 'empowerment'. The following definitions were informed by a review of community development in the international and national health literature.

A community development approach

Labonte's (1993) definition of community development is consistent with the way it has been defined in the Indigenous Australian context: a process of working with communities, in an environment that advocates the full and active participation of all community members, to assist their members to find plausible solutions to the problems they have identified, so that Indigenous people understand and acquire skills to develop culturally appropriate programs and services for their communities (Sherwood 1999). Two types of outcomes can be fostered by a 'community development' approach: (1) improvement in health outcomes by effectively addressing a health issue, and (2) increased individual and community empowerment, which leads to healthier and more equitable power relations (Baum 2002; Labonte 1994).

Community

The recognition that socio-economic status is linked to health outcomes has meant that 'community' has become one of the chief arenas within which to tackle these inequalities (Billings 2000). In the public health and community development literature, 'community' is generally used to refer to categories of people based on identity, geography or issue (Freeman *et al.* 1997; Ife 2002; Kenny 1999; Labonte 1997; Wass 2000). While this definition recognises that communities can take different forms, much of the literature on community development interventions in Aboriginal

Australia describes processes conducted with *geographical* communities. Geographical communities are rarely characterised by harmony and shared values on all issues, and individuals differ in the extent to which they identify with their particular community (Baum 2002; Wass 2000).

Participation

The health development literature describes two types of participation:

- participation as a 'means'—ensuring local people's cooperation/collaboration with externally introduced programs or processes to facilitate the effective implementation of such initiatives and to achieve a set of objectives; and
- participation as an 'end'—the empowerment of people to take greater responsibility for their development through their acquisition of skills, knowledge and experience.

In community development processes participation is valued both as a means *and* an end (Kahssay & Oakley 1999).

Power refers to 'the ability to affect change, not the power to exploit or dominate others' (Ife 2002). Structural and post-structural views of power are most useful in empowerment research. A structural view sees power as being of a limited nature, and empowerment being about challenging and overcoming structural forms of disadvantage and dismantling dominant structures. From a post-structural view, empowerment is considered to be a process of challenging and changing the discourses that support the maintenance of power, and deconstructing discourses that are based on claims of knowledge and expertise (Baum 2002; Ife 2002).

Empowerment

Empowerment consists of 'personal, group and social aspects of power and capacity ranging from leadership, resources and strengthened networks to critical thinking, trusting relationships and increased group participation' (Labonte 1999:430). In the community development context 'empowerment' has been described as a social action process that promotes participation of individuals, organisations and communities in gaining control of their lives both in their community and in the larger society (Wallerstein & Bernstein 1988). Empowerment can operate at the level of the individual, the organisation or the community (Israel *et al.* 1994). Community empowerment has also been described as a process that progresses along a dynamic continuum

of: individual empowerment; small groups; community organisation; partnerships; and political action (Baum 2002; Laverack 2001).

Methodology

Data sources

We searched the CD-ROM databases Australian Medical Index, MEDLINE, APAIS and Sociofile for the period 1994–2004. The following key words were used in combination: *Indig**, *Aborigin**, *Australoid**, *Torres Strait Islander*, *native**, *Indian**, *Maori**, *Inuit*, *community development*, *community participation*, *community involvement*, *capacity building*, *empowerment and participatory action research*. We also searched the Australian Indigenous HealthInfoNet and the Australian Institute of Aboriginal and Torres Strait Islander Studies Bibliography.

Study selection

To ensure the review remained manageable yet could successfully identify relevant studies, we developed a set of inclusion and exclusion criteria. Articles were excluded if they were published before 1994, if they were not available in English, if the study population was not Indigenous, or if the study did not describe an intervention that utilised a community development approach with a view to directly addressing a health issue and contributing to empowerment. 'Indigenous' was taken to include Aboriginal populations in developed countries such as Australia, New Zealand and Canada, due to their shared history of colonisation and dispossession and the ongoing marginalisation of such groups. This is not to suggest that Indigenous people in different countries have experienced colonisation and its impacts in the same way. Rather, that community development interventions implemented with Indigenous groups are likely to have more relevance to Indigenous Australia than those conducted with disadvantaged non-Indigenous people in 'developed' countries or other low socio-economic status groups in Australia. A large proportion of the original 335 studies identified were excluded because they described interventions that involved community consultation or sought

some level of community participation, but were inconsistent with our definition of community development as having an explicit empowerment objective. The identification of only seventeen studies highlights the lack of published literature on the use of community development processes to improve Aboriginal health.

Data analysis

The data were extracted and analysed according to the following five categories: theoretical underpinnings; nature of the intervention; implementation and evaluation methodology; outcomes; and critical success factors.

Methodological limitations

We intended to include the so-called 'grey' literature in this review as many community development interventions are implemented in Aboriginal settings by government departments and non-government organisations, but few are written up in the published literature. Aboriginal community-controlled health services in particular are likely to have extensive experience with community development. However, due to time constraints we did not review the 'grey' literature. A related limitation of this review is the lack of Indigenous commentary that we identified in the mainstream literature on community development. Indigenous researchers and practitioners publishing more on community development would be a significant contribution to the literature in this area.

Discussion

As stated previously, a relatively small number of publications detailing community development processes aimed at improving Indigenous health were identified in the literature review. This reflects the likelihood that community development is *generally done*, rather than theorised, evaluated and written up in the mainstream literature. This section discusses and analyses the seventeen publications (see Table 1) that we identified under the following headings:

- Theoretical underpinnings
- Nature of the intervention
- Implementation and evaluation methodology
- Outcomes
- Critical success factors.

TABLE 1: Authors and title of reviewed papers

Author	Title
Adam & Spratling 2001	Keepin Ya Mob Healthy: Aboriginal community participation and Aboriginal health worker training in Victoria
Braun <i>et al.</i> 2003	Empowerment through Community Building: Diabetes today in the Pacific
Campbell & Stojanovski 2001	Warlpiri Elders Work with Petrol Sniffers
Con-Goo 2003	Self-Development in Order to Improve Community Development: An evaluation of a personal empowerment pilot initiative in Far North Queensland Indigenous communities
Hunter <i>et al.</i> 1999	An Analysis of Suicide in Indigenous Communities of North Queensland: The historical, cultural and symbolic landscape
Lawson & Close 1994	'New Public Health' Approaches among Isolated Rural Aboriginal Communities in New South Wales
McCormack <i>et al.</i> 2001	Learning to Work with the Community: The development of the Wujal Wujal guidelines for supporting people who are at risk
Midford <i>et al.</i> 1994	The Care of Public Drunks in Halls Creek: A model for community involvement
Mitchell 2000	Yarrabah: A success story in community empowerment
Moran 2003	An Evaluation of Participatory Planning at Mapoon Aboriginal Community: Opportunities for inclusive local governance
Rowley <i>et al.</i> 2000	Effectiveness of a Community-Directed 'Healthy-Lifestyle' Program in a Remote Australian Aboriginal Community
Salisbury 1998	A Health Service and Aboriginal and Torres Strait Islander Partnership to Develop and Plan Mental Health Services
Smith <i>et al.</i> 2002	Community Action to Promote Child Growth in Gapuwiyak: Final report on a participatory action research project
Tsey <i>et al.</i> 2002	Indigenous Men Taking Their Rightful Place in Society? A preliminary analysis of a participatory action research process with Yarrabah Men's Health Group
Tsey <i>et al.</i> 2004	A Microanalysis of a Participatory Action Research Process with a Rural Aboriginal Men's Health Group
Voyle & Simmons 1999	Community Development through Partnership: Promoting health in an urban Indigenous community in New Zealand
Warhaft <i>et al.</i> 1999	'This Is How We Did It': One Canadian First Nation community's efforts to achieve Aboriginal justice

Theoretical and conceptual underpinnings of community development and empowerment

Many of the references identified in the initial literature search described interventions labelled as 'community development' and with 'empowerment' objectives, but did not include any detail on the meaning or application of such terms. In most cases these publications described processes that appeared to be consistent with pursuing participation as a 'means' to developing appropriate health strategies and improving health, but not as an 'end' in itself, through fostering empowerment. For example, an article by Canuto *et al.* (2000) reflects the use of a community development approach as a means to reduce injury-related harm within Woorabinda through support for the community to develop and maintain a community-owned injury control strategy. In other cases, statements were made that 'empowerment' had been achieved, but there was no detail as to what empowerment was nor on what basis it was considered to have been fostered. Such references were considered of limited value in this scoping exercise.

Of the seventeen papers selected, a limited number explicitly made the link between community development as a tool for fostering empowerment and control and addressing the social determinants of Indigenous health. Voyle and Simmons (1999), for example, set out the need for using a community development approach in terms of the impact of social determinants on Maori health, and the importance of self and collective efficacy to good health. In their paper, on a partnership to address diabetes in New Zealand, they define community development as the process of organising and/or supporting community groups in identifying their health issues, planning and acting for change and gaining increased self-reliance and power as a result. Empowerment is defined as a social action process that promotes participation of people, groups and communities towards the goal of increased control (Voyle & Simmons 1999).

Other authors made the case for using community development approaches in Indigenous health on the basis that Indigenous people have a *right* to self-determination and to control their own health and futures. For example, the Victorian Aboriginal Community Controlled Health Organisation used a community development process to develop a health worker training course

'based on the conviction that Aboriginal people know what is best for them' (Adams & Spratling 2001:116). In a paper on the use of a community development approach to develop guidelines for supporting Indigenous people at risk of suicide, the use of the approach was based on 'the belief that there must be more opportunities for Aboriginal and Torres Strait Islander people to control their own destiny' (McCormack *et al.* 2001:20). Similarly, the use of a community-driven process to address violence in a Canadian Aboriginal community was described as key to the Aboriginal struggle for self-determination (Warhaft *et al.* 1999).

Other papers rationalised the use of a community development approach for several different reasons. In their report on a community development process to promote Indigenous child growth in a remote NT community, Smith *et al.* (2002) describe the approach as an effective way to address a health issue through the development of appropriate community-based strategies (participation as a means), as well as a means of addressing the social determinants of health by fostering empowerment (participation as an end) and promoting Indigenous self-determination (participation as a right).

While each of the selected papers provided some information on the empowerment and community development theory underpinning the intervention described, this was done to varying degrees. In their paper 'Empowerment through Community Building' Braun *et al.* (2003) provide a detailed argument on how community building was used to empower coalitions to take action around diabetes in Pacific countries, although the focus is on the mechanics of empowerment rather than the nature of power and changed power relationships. They include a useful logic model that demonstrates how community building steps (gaining access to the community, transferring knowledge and skills, building coalitions and providing technical assistance) relate to empowerment outcomes. In turn, a link is drawn between these empowerment-related outcomes and the long-term goal of improving health. Other papers provide limited detail on the concepts themselves and the conceptual relationship between community development, empowerment and health. In many cases it is argued that defining, analysing and acting on one's problem is evidence of empowerment, which is said to be health promoting (Salisbury 1998). While this definition is often used and consistent with the one presented by Labonte in the previous section, it is difficult to appraise and learn from such interventions because of the lack of detail on the theories and concepts underpinning them.

A small number of the interventions reviewed described community-initiated responses to community-identified problems. In these cases, the theoretical and conceptual underpinnings of the process were generally not set out. This does not imply that such responses were not based on sound reflection on the problem and the best way to deal with it, rather the focus was on taking action, not justifying the use of one approach over another. For example, a paper by Campbell and Stojanovski (2001) describes the response of Warlpiri Elders from the Northern Territory community of Yuendumu to the problem of youth sniffing petrol. The strategy was developed and implemented by Elders on a voluntary basis to address this problem. While empowerment objectives were neither articulated nor evaluated, the implementation and sustainability of a community strategy is evidence of Aboriginal people taking control of community health and wellbeing. This suggests that community development processes may be occurring and successfully contributing to Indigenous empowerment in many communities, but they are not being theorised, evaluated and written up in the mainstream literature.

Nature of interventions

Some studies described the use of community development processes to address particular health issues in Indigenous communities. Most of these processes were initiated and facilitated by agencies outside of the community, generally in response to community members expressing concern about the particular issue. Smith *et al.* (2002) describe a two-and-a-half-year community development process implemented by a government health department to address the problem of poor child growth in a remote geographical community in the Northern Territory. This process involved local people defining 'the problem', exploring possible solutions, forming partnerships, mobilising resources and taking steps to implement their solutions. A similar process was implemented by the Cairns District Health Service in the remote Queensland community of Wujal Wujal to support the community to address suicide (McCormack *et al.* 2001).

Several studies described a community-initiated response to a specific health issue, rather than the facilitation of a community development process by an outside agency. The Yarrabah community's response to suicide followed a similar process to those set out above but was driven by the community, which only sought outside involvement when they needed it (Hunter *et al.* 1999; Mitchell 2000). Similarly, a Canadian violence project involved community members

defining the problem and developing a program to treat sexual abuse victims and offenders. Outside involvement was sought when funding was required to implement the community-designed program (Warhaft *et al.* 1999).

Community development approaches were used in some studies to establish 'appropriate' health services for Indigenous communities. For example, in Halls Creek a government department initiated a process to involve local people in decision-making about setting up a sobering-up centre to address alcohol-related problems in the town (Midford *et al.* 1994). In another case, the Tweed Valley Health Service and the 'Aboriginal and Torres Strait Islander community' (presumably a community of interest) developed and delivered a mental health service through a partnership based on participation and empowerment (Salisbury 1998). This process involved the health service supporting a local Indigenous health council to trial and to seek solutions to promote mental health.

Two studies detailed processes designed to improve community health more generally, rather than focusing on a specific issue. A 'new public health' program was implemented by the New South Wales Health Department (NSW Health) in ten disadvantaged Indigenous communities from 1986 to 1990 (Lawson & Close 1994). An Aboriginal health promotion officer was employed and trained and a health committee was established in each pilot site to support a range of activities aimed at improving the physical environment, health promotion, and self-esteem and pride. Another community development process undertaken to improve the general health of a community was the development of a five-year resettlement plan for the remote Queensland community of Mapoon (Moran 2003). This participatory planning process took eighteen months and resulted in a plan to promote the physical and social development of the community, with the overall goal of promoting community health.

Finally, several interventions were more directly concerned with building capacity and promoting empowerment than with supporting a community to address a health issue. A number of papers were reviewed that describe the use of a community development approach to support a men's group in Yarrabah (Con Goo 2003; Tsey *et al.* 2002; Tsey *et al.* 2004). The process is being undertaken with a small group of community members with an initial focus on promoting individual empowerment and self-development. This is being done through the delivery of a Family Wellbeing Program being piloted in Indigenous communities in North

Queensland, which is described in several studies (Con Goo 2003; Tsey *et al.* 2002). This empowerment program first builds the capacity of individuals and then supports the empowered individuals to participate in community-level change. Another study described a project that is forming and building the capacity of coalitions in seven Pacific countries with a shared history of colonisation (Braun *et al.* 2003). While the overall goal is for the coalitions to take action to address diabetes, the project itself is clearly concerned with capacity building and empowerment.

Intervention and evaluation methodology

Most studies would best be described as case studies implemented in a single Indigenous setting without control groups. One exception to this was the 'new public health' program undertaken in ten pilot sites in NSW (Lawson & Close 1994). The program process was evaluated by comparing each community before and after, as well as comparing the ten participating communities with four comparative communities where no intervention had taken place. The authors are careful to spell out that 'the use of the term "comparison" is meant to imply a lesser degree of exactness than the more common term "control"' (Lawson & Close 1994:28). Two other exceptions describe interventions where the primary goal was to build individual and group capacity, rather than to address a community-identified health issue and contribute to empowerment as a result of the community development process. Con Goo (2003) evaluates the piloting of the Family Wellbeing Program in six pilot sites, while Braun *et al.* (2003) describe a capacity-building diabetes program that was implemented in seven different countries with eleven different coalitions.

Further, one study compared biochemical markers and behavioural risk factors for community members who participated in health promotion activities in a remote geographical community and for those who did not (Rowley *et al.* 2000).

According to the National Health and Medical Research Council's 'levels of evidence' the evidence we collected—no randomised control trials (RCTs) and few comparative studies—is low level and has a high potential for bias (Rychetnik & Frommer 2002). However, it can be argued that community development and empowerment interventions are

generally not compatible with these 'high level' study designs because they involve a community responding to an issue of concern. These approaches are predicated on community motivation to address health problems and, therefore, do not fit well with the concept of randomly allocating groups of people into case or control groups. As Rowley *et al.* (2000:143) argue:

A truly 'randomised' design is unlikely to be a useful model for community-based interventions, since communities and individuals choose whether or not to undertake such programs: there is no apparent reason to expect that interventions imposed from outside the community should necessarily receive support from community members.

On the other hand, more comparative studies of similar community development and empowerment processes are required if decision-makers in health agencies are to be convinced of the value of these approaches.

Formative or process evaluations were undertaken on many of the interventions to improve them as they were being implemented. The analysis of the Halls Creek alcohol project includes a useful discussion on the contribution of the formative evaluation to the overall success of the sobering-up service that was established (Midford *et al.* 1994). The evaluation process was key to delineating the purpose, type and possible measures of each subsequent evaluation of the sobering-up centre. The model encouraged flexibility and distinguished between short-term impacts and longer term outcomes. The point is made that outcomes from community development processes take a long time to manifest in quantifiable terms, but subtle changes lay the foundation for further change. The challenge is to design sensitive ways of measuring early change and of 'involving the community in identifying appropriate measures can go some way towards dealing with this problem' (Midford *et al.* 1994:8).

A number of other studies also measured process outcomes rather than quantifiable health outcomes, which take a long time to manifest and are difficult to measure. Lawson and Close (1994) describe a comprehensive process evaluation strategy involving questionnaires and interviews. They justify their focus on process rather than health outcomes due to the difficulty in establishing a causal link between public health programs and health outcomes. Further, they argue that a key priority for Aboriginal communities is to develop programs that are acceptable, affordable and implementable: therefore, it is essential to evaluate process (Lawson & Close 1994).

Participatory action research (PAR) was used in three of the studies and is described as a useful methodology for implementation and evaluation. The Yarrabah men's group is being supported to plan, implement and evaluate activities through a PAR approach. This allows community members to act as researchers exploring priority issues affecting their lives, to recognise their resources, to produce knowledge and to take action to improve their situation with support from researchers (Tsey *et al.* 2002). PAR is being used to undertake a formative or process evaluation of the empowerment intervention, as well as contributing to empowerment outcomes. A system of ongoing reflection and action has been developed which is based on participant observation, informal discussions and in-depth interviews (Tsey *et al.* 2004).

Smith *et al.* (2002) also used a PAR methodology because of its compatibility with community development. They argue that PAR shares the same process and empowerment principles as community development, but involves a method of systematic investigation. In this case, the PAR framework is described as both contributing to and constraining the community development approach. On one hand, the power sharing, critical reflection and action-orientation of the methodology supported the achievement of project outcomes. On the other, conducting the community development process within a research framework created a set of requirements that were not conducive to fostering community control and participation. For example, the need to articulate a detailed research plan in order to secure funding, and the use of standard research methods and instruments undermined the capacity of community members to set the agenda.

The fact that this issue was described in other studies suggests it is not directly related to the PAR methodology but more to do with how community development interventions are generally researched and evaluated. The diabetes partnership project analysed by Voyle and Simmons (1999) aimed to evaluate both the project process and outcomes. While their paper outlines the process evaluation, they refer to the impact of the outcome evaluation (which focused on quantitative assessment of diabetes risk factors) on the project process. The 'medical model requirement for quantitative pre- and post-programme measures' had two negative effects on the process (Voyle & Simmons 1999:1043). First, it limited the discretionary power of the partnership committee who wanted to provide health education before screening but were restricted by the evaluation design. Second, the minimum sample size

required to attach significance to the scores took nine months to meet. This created a time gap that meant a loss of momentum and the departure of some Maori staff trained by the project before the health promotion intervention commenced. It is concluded that while quantitative methods are useful they should not be 'superimposed in a manner that interferes' with community development or empowerment (Voyle & Simmons 1999:1046).

Few studies sought to evaluate empowerment outcomes comprehensively. As noted in the section on theory, in many cases empowerment was defined as local people taking action on problems and this was evaluated by assessing the presence or absence of community action. Conversely, those studies that comprehensively set out what empowerment was and how it could be fostered also sought to evaluate empowerment outcomes. A good example of this are the studies on the Family Wellbeing Program (Con Goo 2003; Tsey *et al.* 2002). The researchers supporting the PAR process are undertaking a ten-year research program to explore how empowerment can be used to understand and address the social determinants of health. This long-term approach involves regular group discussions, interviews, critical reflection and feedback to promote and assess empowerment.

Outcomes

Involving Indigenous participants in designing and implementing health initiatives

Most studies reported on the successful use of a community development process to involve community members in developing and implementing locally appropriate health initiatives. For example, one successful outcome of a Cairns-based suicide prevention project was Indigenous community members developing 'culturally appropriate guidelines' for working with people at risk of suicide (McCormack *et al.* 2001). It is anticipated that these guidelines will promote community-owned responses that will increase self-reliance. However, the success reported on to date is the development of the guidelines themselves. Similarly, Voyle and Simmons (1999) report on the strong participation of Maori in establishing and then taking control of their own health group and diabetes program as successful outcomes.

Changed health behaviour

Several studies described both the establishment of a community health initiative as well as the positive impact

of the initiative on health-related behaviour as evidence of success. In one case, petrol-sniffing activities run by Warpiri Elders led to a decrease in the number of young Indigenous people sniffing petrol (Campbell & Stojanovski 2001). Similarly collective action taken by members of the Yarrabah community to address youth suicide resulted in a marked halt in youth suicide and a substantial reduction in self-harm (Hunter *et al.* 1999; Mitchell 2000).

Empowerment

In most cases, the development and implementation of a health initiative by Indigenous community members was described as evidence of empowerment. Indigenous participants developing an acceptable and well utilised mental health service is cited as evidence of empowerment in a rural area in Queensland (Salisbury 1998). Other examples of this type of reporting on empowerment include the successful establishment of a sobering-up service in Halls Creek in Western Australia and the development of a health worker training course in Victoria, both of which relied on strong Indigenous participation (Adams & Spratling 2001; Midford *et al.* 1994).

Several papers refer to empowerment as evidenced by the establishment of a health initiative with Indigenous involvement, as well as specifying the aspects of community action that are considered to be evidence of empowerment. For example, a diabetes project conducted in seven Pacific countries increased individual competence, enhanced community capacity, reduced barriers and improved supports for diabetes control (Braun *et al.* 2003).

These aspects of empowerment are discussed in detail and examples are provided to support the empowerment claims made. Another body of empowerment research to report comprehensively on empowerment outcomes is that of Tsey and colleagues on the Family Wellbeing Program. Their papers help operationalise the concept of empowerment by describing the specific outcomes of the program at the individual, group and community level. They describe significant changes in the behaviour of the men involved and an increased sense of self-awareness, self-confidence and hope for the future. The men's group is also showing signs of empowerment by supporting each other to address their problems collectively. Further, there are

signs that the problem-solving skills individuals are acquiring are having a ripple effect as people work together to affect community change (Tsey *et al.* 2002).

Improved health

Only two studies sought to assess changes in physical indicators of health as a measure of the success of the community development approach. Rowley *et al.* (2000) describe modest, sustained improvements in biochemical and behavioural risk factors as a result of the Looma Healthy Lifestyle Project conducted in a remote community in Western Australia. They suggest that participation in the project may have contributed to community members having a greater sense of control over events. This, in turn, may have meant that participants were more likely to undertake and sustain intervention strategies, resulting in metabolic improvements in relation to the comparison group. While the possibility of a relationship existing between increased control, empowerment and physical changes is flagged, increased control and empowerment were not assessed.

A study in which the primary author was involved sought to evaluate improvements in child health, in addition to the establishment of a health initiative and empowerment outcomes (Smith *et al.* 2002). Analysis of the quantitative data collected (which was not reliable due to inadequate coverage) did not show an improvement in child growth according to weight over the two-year project period. This was primarily attributed to the inadequate project time frame and the unrealistic expectation that there would be a measurable health outcome in two years. Despite demonstrating that the community development process contributed to the development of a locally appropriate and sustainable child health strategy, as well as empowerment at the individual and group level, the success of this project was questioned by some staff from the implementing health agency as quantifiable health improvements were not demonstrated. In this instance, seeking to evaluate health outcomes prematurely undermined the value attributed to the community development process by detracting from the less tangible empowerment outcomes achieved (Smith 2003).

It is not possible to draw conclusions about the empowering potential of the different interventions reviewed and to make recommendations about the value of one over another. The conceptual ambiguity surrounding empowerment means that the study authors have given different meaning to the term, which affects how they seek to foster empowerment and how they evaluate it. Developments that might be taken

as signifying empowerment under one conceptualisation might not be considered as so significant under another. This highlights the need to develop a workable concept of community development and empowerment that can be implemented and evaluated in the Aboriginal health setting. It also highlights the need for long-term community development processes combined with evaluations that have the potential to demonstrate significant outcomes.

Critical success factors identified in the literature

Community ownership of the problem and solution

Community definition and ownership of the health problem being addressed by the project was repeatedly identified as key to the involvement of local people in designing and implementing health strategies. The Yarrabah community is described as having progressed through a series of stages before entering a state of full ownership of the suicide problem (Mitchell 2000). This full ownership stemmed from an understanding that lasting solutions could only be found within the community itself, which manifested a widely shared community commitment to action. This process was described as slow and accompanied by much pain and grief over a long period of time, but pivotal to the community's success in reducing youth suicide and self-harm.

Existing community empowerment and local setting

Existing community empowerment and the local community context were also critical success factors. The Warlpiri response to petrol sniffing was partly attributed to community members having already been empowered by a previous family counselling program that equipped people with the skills to cope with any ongoing problems (Campbell & Stojanovski 2001). The Yarrabah community's ability to address the alarming rate of suicide was partly attributed to changes in the community context including the establishment of a community council (Hunter *et al.* 1999). This empowered community members and contributed to an increased sense of community responsibility. In turn, the community-driven process led Yarrabah residents to take greater control over decision-making about health and a community-controlled health service was established. This health service then established the men's group described by Tsey *et al.* (2002), which is now contributing further to individual and community empowerment.

The employment of local facilitators

Employing local Indigenous people as team members and training them in community development skills and processes contributes to successful community development. A NSW public health program employed Aboriginal health promotion officers who completed an associate diploma in health and community development as part of their work (Lawson & Close 1994). The combination of the professional skills they acquired from this training and the personal characteristics they brought to the program (mature interpersonal skills, knowledge about health promotion, and commitment to and participation in the affairs of the community) enabled them to play a leading role in health promotion. Similarly, employing community-based liaison workers was key to the success of the New Zealand diabetes project (Voyle & Simmons 1999). Conversely, the lack of training provided as part of the Mapoon participatory planning process was identified as limiting capacity building (Moran 2003). A number of studies argue that more attention should be given to identifying the types of skills needed and how these skills can be taught, so that local people can use community development approaches to bring about social change in Indigenous communities (Smith *et al.* 2002; Tsey *et al.* 2004).

The role of outsiders

'Outsiders', or external community development facilitators, play an important role in providing information about health problems and possible strategies to address them. While the Yarrabah response was community driven at all stages, researchers and visiting health professionals provided information on suicide and stimulated critical reflection among community members on its underlying causes, a process that contributed to the community taking ownership of the problem (Hunter *et al.* 1999). Similarly, in Halls Creek local people were concerned about alcohol-related problems but had limited knowledge of possible solutions (Midford *et al.* 1994). The research team involved provided information on the range of possible services that could be established, contributing to the community taking action.

Establishing trusting partnerships

A related factor that promoted success was the establishment of trusting partnerships between Indigenous community members and outsiders over time. Voyle and Simmons (1999) describe the lack of trust that existed between Maori community members and non-Maori or dominant culture members at the start of their project. They

attributed this to the history of colonisation, the experience of government agencies subverting self-determination by tying funding to compliance, the activities of previous researchers in not returning research benefits to communities, and the perception of self-servicing agendas on the part of bureaucrats, particularly health managers (Voyle & Simmons 1999). The reluctance of Maori to be 'used' again—a common theme in these factors—was addressed by adjusting the project time frame to allow trust to build. Over time, Maori participants saw that the project team was genuine in its commitment to developing a respectful partnership where power was devolved from health professionals to Indigenous people. The Gapuwiyak Child Growth Project similarly found that the deeply embedded power inequalities between Indigenous community members and the non-Indigenous researchers and health professionals made it difficult to work in partnership in the early stages (Smith *et al.* 2002). A productive partnership was established over time as relationships developed and the supportive, rather than directive, role of the researchers became evident from their practice.

Establishment of a local committee

The formation of an Indigenous committee that took a leadership role in community development processes contributed to the success of several interventions. In the Halls Creek project an advisory group, consisting of both local people and government workers, acted as a conduit for community perspectives, provided a means of liaison with relevant government agencies and was responsible for keeping the communities informed about progress (Midford *et al.* 1994). In Gapuwiyak, the local action committee developed and implemented a strategy to promote child care and development (Smith *et al.* 2002), while a partnership committee of Maori and health professionals played a leading role in the New Zealand diabetes project (Voyle & Simmons 1999). Key to the effectiveness of this committee was operating with a framework of values centred on empowerment, mutual respect, self-determination, and incorporating cultural community knowledge and strengths.

Adequate internal and external resources

Finally, adequate internal and external resources are central to the success of community development processes (Braun *et al.* 2003). Even where processes were initiated and driven by community members, appropriate resources from inside and outside the community contributed to their positive outcomes (Hunter *et al.* 1999; Warhaft *et al.* 1999).

Conclusion

There is limited mainstream literature on the theory, implementation and evaluation of community development and empowerment interventions in Aboriginal Australian settings. In particular, there is a lack of Indigenous commentary in the mainstream literature. The general lack of community development discourse in the Australian academic literature cannot be attributed to a decline in community development practice. To the contrary, it has been argued that while 'community development has virtually disappeared from academic and bureaucratic discourse, it has remained alive and well in a thousand guises in the field' (Onyx 1996:101). Hunter (1998) notes that across Indigenous Australia there are now many examples of community development projects, which have had varying degrees of success, yet only a limited number of these have been written up in the mainstream literature. Community development is generally done by practitioners rather than theorised by academics. However, to improve both the theory and the practice, community development intervention should be implemented and evaluated in order to investigate their potential to improve Aboriginal health through participation and empowerment processes.

Few published articles comprehensively and critically describe and evaluate community development processes. Many papers identified in the initial search either detailed aims and objectives, without mention of the actual outcomes, or made sweeping claims about people having been empowered without describing the process and the evidence of this outcome. The Australian community development literature generally has been criticised for its tendency to make grand claims about the transformatory nature of such work, none of which are supported in the programs reported on (Mowbray 1996).

Only six of the studies we reviewed comprehensively explore the concepts of community development and empowerment and their relationship to health, describe the community

development intervention in detail, include an evaluation strategy, and clearly set out how they were judged to have contributed to empowerment. These studies provide much insight into community development processes and their potential to contribute to empowerment outcomes. Similarly, detailed studies of community development interventions are needed to assist us to understand and address the social determinants of Indigenous health through fostering empowerment. Ideally, such studies would start with a shared concept of community development and empowerment, because differences in the meaning given to these concepts by practitioners and evaluators affect their operationalisation and, therefore, judgments about the empowering potential of such schemes (Bridgen 2004).

Factors critical to the success of community development interventions in fostering empowerment in Aboriginal settings include: community members owning and defining their problems and solutions; existing community capacity and empowerment and a context that supports local involvement in promoting health; employing local people and training them in community development skills and processes; the role of outsiders in providing information about health problems and possible action strategies, as well as in stimulating critical reflection; the formation and active involvement of a local committee in all aspects of the community development process; the development of trusting, respectful partnerships between Aboriginal community members and outsiders over time; and adequate resources both from within and outside the community. The evaluation of long-term community development interventions would generate further evidence to confirm the importance of these factors.

The literature we reviewed suggests that long-term research is required to determine the potential for different community development interventions to contribute to empowerment and improved health outcomes. More work is required to develop appropriate, practical methodologies for evaluating interventions that seek to understand and address the social determinants of health by promoting empowerment and control through community development processes. A starting point for developing practical evaluation methodologies is making clear how the term 'empowerment' is being understood and, on this basis, establishing the indicators of community development on which judgments about success will be based.

Both community development interventions and evaluation methodologies should be flexible enough to be responsive to community direction. At the same time, evaluation

methodologies should be comprehensive enough to evaluate the range of outcomes generated by empowerment interventions. Methodologies should evaluate both processes and impacts on health behaviour, such as increased use of health services. Health outcomes should not be evaluated until measurable health improvements can realistically be expected. Appropriate evaluation methodologies are likely to draw on a range of methods, both qualitative and quantitative. While qualitative evaluation is the key to understanding processes and assessing empowerment, the measurement of quantifiable health outcomes is likely to be central to influencing policy-makers in health agencies. A transdisciplinary approach involving teams of people from different disciplinary backgrounds may prove the most effective way to implement and evaluate community development interventions. The involvement of industry partners in such teams would maximise the likelihood of research findings being translated into health service practice. Participatory Action Research is one approach that appears to be useful in the implementation and evaluation of community development projects and processes, largely because it shares a similar process and set of objectives. At the same time, like other evaluation methodologies, care must be taken to ensure that PAR is not constrained or made too cumbersome by research requirements. If this occurs, the evaluation may undermine community development processes aimed at generating community action and empowerment.

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