ORIGINAL ARTICLE

Fostering Health Creation: Community Development to Address Long-term Conditions

促进健康创造：社区发展，解决长期环境

Fomentar la generación de salud: el desarrollo comunitario para abordar dolencias a largo plazo.

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INTRODUCTION

Non-communicable chronic disease (NCD) is fast becoming the leading cause of morbidity and mortality in the world, mainly as a result of heart disease, stroke, cancer, diabetes, and chronic respiratory disease. While these problems are partly the consequence of better prevention and treatment, they have become major barriers to development goals including poverty reduction, health equity, economic stability, and human security.

The United Nations (UN) Plan for control of NCD focused on behavioral interventions—tobacco control, salt reduction, improved diets and physical activity, reduction in hazardous alcohol intake, and essential drugs. However, success in making large social changes in behavior requires that we go beyond treatment and delivery of information by healthcare practitioners to more effective changes delivered outside the medical encounter.[1]

The vast majority of successful behavioral change is driven by social and environmental influences, not by healthcare. An Institute of Medicine (IOM) report suggests that new, non-medical models for changing the social determinants of health are needed.[2] One key approach is to harness ways to engage communities in the process of their own health creation. These processes require empowerment of communities and the development of standards and measures for successful community engagement in the whole process of behavior change and health creation. In the recent report *Shorter Lives, Poorer Health*, the IOM compared trends in top health indicators across 17 countries.[3] Countries that invested more in community development (CD) than advanced medical treatment had better trends in the majority of health indicators.[2] Other studies, such as that by Bradley et al, have also documented the significant and independent impact of social services and community development investment on most major health outcomes.[4]

This article explores community development in health, focusing on describing how it works on the ground, the evidence base for clinical and cost effectiveness, and gaps in that evidence.

STRATEGIC APPROACHES

Community development is a method of working with communities to enhance their strengths. It includes processes that identify strengths defined by the community. As will be described later in the article, this can lead to challenges and shifts in power. Both traditional public health and conventional medicine have a long history of giving people answers to questions that have not been asked by their community. CD assists public health and medicine by supporting the community's search for answers to community-generated questions. By working with communities in a proactive and engaging way, we can help communities decide on their priorities for change. They can then help in bringing the variety of responsible agencies together to collaborate with the community and each other, thus creating a self-sustaining environment. CD sprung from low-income countries decades ago and is now exporting it back. The UK National Occupational Standards for CD[5] as a long-term value-based process aims to address imbalances in power and bring about change founded on social justice, equality, and inclusion. The process enables people to organize in order to:

- identify their own needs and aspirations;
- take action to exert influence on the decisions which affect their lives; and
- improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

CD is a set of techniques for increasing the volume and quality of community activity in a given population ("the community") at two levels:

1. **within the community itself**: to increase social networks and productivity—more friendships, less isolation, more volunteering, more mutual aid, more informal care, better flow of information, more trust and cooperation, and more behavior change;
2. **between the community and local services and authorities**: better communication, dialogue, feedback, engagement, and involvement in service change and shared governance.

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Action across a locality crystallizes in the form of a range of independent community groups and networks or public service user groups, such as sports clubs, careers' groups, and youth clubs. Some are generated wholly by local residents; others are stimulated and supported by skilled enablers. Handfuls of people run such groups continuously, with more help occasionally, and a larger number still use their services or benefit from their activities. Most statutory agencies are aware of the local voluntary sector or a few community groups. What is less understood is that this sector is much more extensive if you include all the small and low-profile groups. Collectively, they have a major effect both directly on health and on the local population's ability to engage with health agencies. This sector is weaker and more sparse in disadvantaged areas that make the most demand on the health services.

CD can play a significant role in local development by assisting new groups to emerge and helping both new and existing groups to negotiate with health agencies and other public bodies to improve services. For instance, community development work in a small town in southwest England enabled change across a range of sectors, including:

- A new dental service established
- Funding of £95 000 (157482 USD)to transform a derelict area into a play park
- Planning for a new general practice surgery (clinic)
- Well attended social events and football sessions
- Improved relations with the housing department with tenants more satisfied
- Summer holiday activities for all ages
- A cooperative plan for social renewal agreed upon between the community and public agencies[6]

The World Health Organization (WHO) European Office for Investment for Health Development uses the term *health assets* to mean the resources that individuals and communities have at their disposal, which protect against negative health outcomes and/or promote health status. These assets can be social, financial, physical, environmental, or human resources; for instance, education, employment skills, supportive social networks, natural resources, etc (Figure 1; Box 1).[7,8]

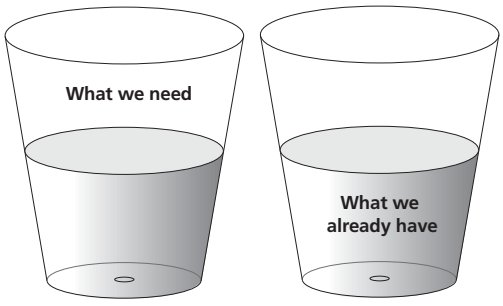

Figure 1 Asset-based community development.

Box 1 Asset-based Approaches

- Working together, asset-based approaches complement the conventional model by identifying the range of protective and health-promoting factors that act together to support health and well-being and the policy options required to build and sustain these factors.
- Seeing the population as a co-producer of health rather than simply a consumer of healthcare services, thus reducing the demand on scarce resources
- Strengthening the capacity of individuals and communities to realize their potential for contributing to health development
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors

MANAGING COMMUNITY DEVELOPMENT

CD is best carried out through trained community development workers and with trained frontline service workers. The process begins with identifying the key issues that matter most to residents who are prepared to take local action, remembering that all issues have a benefit on health and well-being if tackled collectively. The underlying evidence base for this work, outlined later in the article, is that CD stimulates and deepens social networks, which in turn are health protective. The actual issues are important to the community, but are probably irrelevant to health gain. If the most ready residents want to start by dealing with antisocial behavior, housing, or environment, those become the initial priorities for the work. If social networks are expanding, the most relevant major issues will emerge. Then local agencies can more likely be persuaded to give their frontline workers space to get involved and to learn to see local residents as assets and sources of solutions, not merely as presenting needs (Box 2).

Box 2 Asset-based Work in Atlanta, Georgia

Jim Diers at the School of Education and Social Policy in Northwestern University, Seattle, Washington, describes an institutional policy shift in Atlanta's services for regenerating community, creating a space for the "citizen centers" to grow, and a policy that shifts from prescription to proscription, from "how we will fix them" to "what we won't do to limit them." The shift of approach includes:

- From a focus on deficiencies to a focus on assets
- From a problem response to opportunity identification
- From a charity orientation to an investment orientation
- From grants to agencies to grants, loans, contracts, investments, leveraging dollars

There is a variety of evidence[6] that, as communities begin to work together with agencies to solve the problems that matter to them, confidence grows, leaders appear, social capital improves, and the benefits to health become apparent. Some impacts are direct, through the effects of participation on individuals; some are indirect, through service change and increase in social trust.

Things have changed: people are more confident in the agencies, and services, people can come up and talk to them and know that they're here, rather than go through five different phone numbers to find the right person. The result is instant, which makes them happier. It's about making things better here; it brings the confidence back in the residents.

— Local coordinator in a CD project in the United Kingdom

Once a significant proportion of people in an area take charge of their collective conditions, through a partnership of community groups, they can negotiate with statutory agencies to influence service delivery.[9] A resident-led partnership is often the vehicle by which this transformation takes place. This brings together independent voluntary local community groups with public agencies dealing with health, education, housing, police, and other issues in ways that have often not happened in that area before.

People say that the people round here are apathetic. They do care, but they've been promised so many things that haven't happened that they get negative about it. They feel no one's listening to them, and for me, I felt I wanted to be involved in a group like this, because people deserve to have a voice. It has done that. And the most important thing that TCP did, before it tried to get involved with people, it got all the agencies you could think of to come on board and come to a meeting and talk about what we were going to try and do, that's the best part of it, because before that people might contact, say Tor Homes [Devon & Cornwall Housing], who wouldn't give them a satisfactory answer, and now with the Partnership, we can put people in touch directly with whoever it is they want to be connected to.

— Resident A in a CD project in the United Kingdom

From our practical experience, it has become possible to outline some principles underlying successful CD work.

In CD, power shared is power enlarged. Imagine a line of candles. The first one is lit and then used to light the next candle and keep going. Eventually, there is more light for everyone—and everyone has contributed (Box 3).

Box 3 Principles of Community Development

Start with the people.
We need to ensure that the agenda for the work is set by local people. It is their community and they understand the key issues that affect them. They are also likely to have solutions; if only they had the assistance to implement them. Statutory agencies need to understand that and help, not hinder.

See the local population as a productive force.
Public services cannot expect to effect transition through negotiation with each other. The relationship of each of them with the community is the necessary medium for the service interrelationships they are seeking. It is through meeting on the community ground that they actually see how the impact of their particular service interacts with the impacts of the other services. The community's experience of weaving together all the service impacts is the crucible for a more integrated view.

Do not start from a public health or other clinical agenda.
Do not begin the work by thinking, "These people drink too much, smoke, and are overweight. We need to intervene to improve health outcomes." The evidence shows that, by working on the issues that matter to them, local communities gain health protection and resilience, which makes it easier to tackle more conventional health issues.

Use experienced and effective CD workers.
The task is difficult and complex with many competing pressures.

Remain value-based.
Address imbalances in power and bring about change founded on social justice, equality, and inclusion.

Harness asset-based approaches.
Assume that local leaders will appear. There are always important assets in a locality: local skills, such as traditional medicine; local experience, such as ways of change that have worked in the past and local customs. We need to see local people as solutions, not problems to be solved.

Build on existing groups.
There will always be local associational life. Harness that to begin with. The energy may lie there, or maybe new groups will need to be created.

Different techniques are needed for different places and cultures.
The approach cannot be stereotyped. Each community must build its own models and techniques that fit its assets, history, and context.

Power is not a zero sum game.
CD is committed to shifting the balance of power toward the community and the individuals within it.

EVALUATING OUTCOMES: THE EVIDENCE AND THE GAPS

Social networks are the connections we have with other people—friends, relations, acquaintances, work colleagues. Social networks are weaker in more deprived areas.

Assessing the Value of Community-based Prevention[2] proposes an evaluative framework that is comprehensive and includes the assessment of the benefits, harms, and resource use of community-based prevention in the three major domains of health, community well-being, and community process. While measures for health are well developed, measures for community well-being and process are poorly developed or nonexistent.

Social networks protect physical and mental health by increasing resilience. Social networks are a simple concept: they are the connections one has with other people—friends, relations, acquaintances. Social networks and social participation appear to act as a protective factor against dementia or cognitive

decline over the age of 65 years and social networks are consistently and positively associated with reduced morbidity and mortality.[10] Loneliness and low levels of social integration significantly increase mortality.[11] Social networks are weaker in more deprived areas but are often a key asset of the community on which to build. The most significant difference between people with and without mental illness–related health problems is social participation.[12-14]

Time banking is a form of coproduction. It is a means of exchange used to organize people and organizations around a purpose, where time is the principal currency. For every hour participants "deposit" in a time bank, perhaps by giving practical help and support to others, they are able to "withdraw" equivalent support in time when they themselves are in need. In each case, the participant decides what he or she can offer. (http://www.timebanking.org/about/what-is-a-timebank/) Time banks improve mental health through social networking.[15] There is strong evidence that social relationships can also reduce the risk of depression.[16]

A 2010 meta-analysis of data across 308 849 individuals followed for an average of 7.5 years shows a 50% increased likelihood of survival for people with stronger social relationships. This is comparable with a reduction in risks such as smoking, alcohol, body mass index, and physical activity and is consistent across age, sex, and cause of death.[17]

Increasing social networks also improves trust, confidence, and the ability to find work. Improving links between people has other beneficial outcomes as well. Those areas with stronger social networks experience less crime[18] and less delinquency.[19,20] Social networks enhance employment and employability.[21] Social cohesion and informal social control predict a community's ability to come together and act in its own best interests, yet they derive, at least in part, from participation in local associations or organizations.[22]

Effective community development builds social networks, helps people take more control over their environment, and tackles health inequalities. Minkler is clear that CD builds social networks, communities, and improves health.[23] CD work on the Beacon estate in Cornwall (United Kingdom) showed significant sustained changes defined and designed by the community. Once the people of the community worked together and saw that they could make a difference, confidence rose and improvements in housing education, health, and crime resulted. Similar results have been seen in Balsall Health (Birmingham, United Kingdom).[24]

The "Linkage Plus" program developed and deepened social networks for older people while redesigning services with their help. Significant improvements in health and independence resulted,[25] including:

- older people having new opportunities to socialize through involvement in social, training, leisure, and networking activity;
- creation of employment, self-help, and volunteering opportunities, which developed new skills and social capital through the engagement and empowerment of older people;
- market development resulting in new organizations being created to work with, and for, older people by partnerships of statutory, third sector, and private organizations;
- market development resulting in new preventive services being created by statutory, third sector, and private organizations either individually or in partnership to work with, and for, older people;
- multiplier effects, where older people, either individually or collectively, have been at the center of policy development and service design and empowered to identify outcomes and create innovative solutions.

WHO recommends that one approach to tackling health inequalities is reducing social isolation by enhancing community empowerment.[26]

Increasing control over one's environment enables a new relationship with agencies, which results in more responsive local statutory services and helps tackle health inequalities. Local governments find community engagement and empowerment—in good and difficult times—saves time and money, creating more satisfied communities.[27] Once people in an area take charge of their destiny, they can negotiate new relationships with statutory agencies that can then, in turn, develop new, improved, and appropriate forms of service delivery.[9] Making resources available to address the association between poor health and poor social networks and breaking the cycle of deprivation can also decrease costs of healthcare.[28]

The quality of public service responses maintains resilience and capability in the face of economic and other adversities.[29] Marmot makes it clear that the state and its services are critical to enabling control and independence.[26] LinkAge Plus combined self-help and independence, peer support, social inclusion, taking part in meaningful activities, advocacy and support and included support that is responsive, personalized, and dependable. Small, simple interventions designed by local people had significant beneficial effects.

COST BENEFIT

The technique of social and financial return on investment has been used to examine four examples of CD.[30] This report tracks the cost benefit of a CD worker in each of four local authorities, identifying, supporting, and nurturing volunteers within their areas to take part in local groups and activities. The results indicated that for an investment of £233,655 (387 371 USD) in community development activity by the four CD workers, the social return was approximately £3.5 million (5.8 million USD)—a return of 15:1. The time

invested by members of the community in running various groups and activities represented almost £6 of value for every £1 invested by a local authority in employing a community development worker.

Knapp explored this in a different way. He used a cost-benefit approach and decision-modeling techniques to examine potential costs and economic consequences in a context where evidence is limited and there is little opportunity to collect primary data. He concluded that there could be sizeable savings to the public purse when investing in community capital-building initiatives at relatively low cost.[31]

The UK Healthy Communities Collaborative reduced falls in older people through combining CD with targeted outreach to this section of the community. In three sites, covering a population of 150000, there was a 32% reduction in falls (730 fewer falls over 2 years). This is estimated to represent a reduction in hospital costs of £1.2 million (2 million USD), in ambulance costs of £120000 (198961 USD), and in the costs of residential social care by £2.75 million (4.56 million USD).

Lomas[32] estimates that for every 1000 people exposed to each "intervention" per year:

- Social cohesion and networks of associations would prevent 2.9 fatal heart attacks or heart failure.
- Medical care and cholesterol-lowering drugs would prevent 4.0 fatal heart attacks in screened males.

Time banks are a useful technique, especially in economically disadvantaged areas. Time banks use hours of time rather than money as a community currency: participants contribute skills, practical help, or resources in return for services provided by fellow time bank members. The cost per time bank member averages less than £450 (746 USD) per year but could result in savings and other economic payoffs of more than £1300 (2,155 USD) per member [31]

Engagement leads to fewer complaints and saves money.[33] Having an engaged community can also prevent issues such as vandalism. On a £2.2-million (3.65 million USD) housing redevelopment project for the Shoreditch Trust (London, United Kingdom), consultants estimated that the additional costs saved from community engagement were about £500,000 (828827 USD) (Boxes 4 and 5).

Box 4 What Community Development Can Do

Evidence is accumulating that CD, through building social networks:

- improves health protection and resilience
- improves the outcomes of patient and public involvement
- facilitates behavior change
- helps tackle health inequalities
- probably saves money

Box 5 Gaps in the Research Evidence

Rural vs urban
It is not clear whether different approaches are needed depending on the geography of the communities.

How to systematize
The current distribution of community development in health is sporadic. If we want benefit to be spread and disseminated, what is the best way to accomplish this?

Many variants—can we tell which is better?
Partly because the field has grown organically, there are many variants of CD. Which suits which situation best? Can we describe the differences clearly and then match which are most suitable in which situation?

What are the health outcomes?
The evidence base is extensive for health gain. However, the benefit is presumed. This is because we have good evidence that CD improves social networks—and improving social networks improves health.

What are the impacts on healthcare usage?
We have very limited knowledge about whether CD makes a difference to the demand for healthcare.

SUSTAINABILITY

There are a number of examples that show that CD continues in a community long after the CD worker or other catalyst retires from the scene. The Beacon project in Cornwall has been self-sustaining for 15 years, and work on the Balsall estate in Birmingham, United Kingdom, for 10 years. The format suggested by Health Empowerment Leverage Project (HELP, www.healthempowerment.co.uk) is that the CD process includes training local people as well as local statutory agency workers to continue the process after the initial intervention is over.

Other approaches are also emerging, such as Social Impact Bonds in which private, for-profit organizations work with the community to implement programs, which, if they save public money, share in the risk and profit.[34] There are still significant gaps in the evidence for these initiatives that must be addressed before there is widespread adoption of this approach.

Health Empowerment Leverage Project, HELP, concentrates on a particular form of community development, the creation of a long-term problem-solving neighborhood partnership between residents and frontline services from health and other agencies. The partnership is led by residents but generates parallel action and learning among agency staff with the development of confidence, skills, and cooperation. The aim is not only to widen and multiply existing activities but to create a cumulative momentum so that such developments are self-renewing, and the whole atmosphere of the neighborhood becomes more positive. A video about the project is available here: https://www.youtube.com/watch?v=Qj_W7QxPeM8&feature=youtu.be

HELP adopted a method known as "C2" (http://www.healthcomplexity.net), which had a reputation of exceptional success over 15 years of experience across six deprived rural and urban estates. A review of the longer-term effects of a C2 project run on the

Beacon Estate in Penwerris, Cornwall, found major improvements between 1995 and 2000 in education, health, employment, and crime.[2,9] Attempts to substantiate these statistically remain uncertain as numbers were small and chains of cause and effect were complex, but improvements appeared to outstrip national trends at the time. Comparable results have been seen in Balsall Health, an estate in Birmingham that independently developed a similar method.[10,13,14]

In this approach, a facilitator leads the residents and agency staff through a seven-step program. HELP ran a small number of local projects directly and provides training based on the C2 seven-step method to enable local people—both lay and professional—to apply the system in their locality and link with the growing network of HELP and C2 projects.

SYSTEMATIZING HELP THROUGH TRAINING

HELP continues to run a small number of local projects directly and provides training based on the C2 seven-step method to enable local people—both lay and professional—to apply the system in their locality and link with the growing network of HELP and C2 projects. Following are some examples.

GLOBAL EXAMPLES OF COMMUNITY DEVELOPMENT

In Pakistan's Punjab province, women in three communities—Rehmatabad, Yazman, and Ather—have been actively engaged as community organizers, mobilizers, and change managers (Figure 2). The results have been a significant improvement in access to clean drinking water, which has had a dramatic impact on education, health, economics, and women's empowerment. The improvement efforts had their roots in the Public Health Engineering Department (PHED), a provincial government department that has a mandate to supply drinking water to rural populations of the province. In the mid 1990s, PHED began institutional reforms to improve service delivery in rural areas by empowering communities. The community development unit (CDU) under the Rural Water Supply project funded by the Asian Development Bank (ADB) initiated social mobilization and active participation—especially of women—in the project cycle. Through this mobilization effort, a group of women leaders emerged in each community who played a very significant role in achieving the project's initial targets. The department thereby realized that supporting women's involvement and their leadership role had a significant impact on a community's success. The Water and Sanitation Program (WSP)—through its newly launched Women in Water Initiative (WiWi)—conducted case studies in Rehmatabad, Yazman, and Ather in Punjab, Pakistan, to document the role of women in RWS planning, decision making, community development, entrepreneurship, and operations and maintenance. Findings from those case studies show dramatic improvements in several key areas, including economics, education, and health.

Figure 2 Women as community organizers. Photo credit: World Bank.

Prior to the projects, women spent most of their day gathering water. In Rehmatabad, for example, women had to walk 2 to 4 km and wait in line for 4 hours for their turn to collect water, an effort requiring 6 to 8 hours each day. The installation of domestic water connections in all three communities has eliminated this water collection effort, freeing women to pursue economic and education opportunities (Figure 3).[35]

Figure 3 A traditional healer in Mali. Photo credit: Brian Fisher.

A PLACE FOR TRADITIONAL MEDICINE

CD has a natural affinity to traditional medicine (TM), especially in those places where TM practices are widespread and popular. TM is often locality based and offers disseminated leadership in the sense that, to some degree, ordinary people can use key elements of the skill without training. It is often embedded in the culture and is less expensive and more trusted. Complementary medical practices that have similar philosophies of healing to traditional practices may be more readily accepted than biomedical approaches in a

number of commmunities. The preference for traditional and complementary practices needs to be respected and worked with and not reflexively discounted as "quackery" or "magic." Indeed, we have explored whether an appropriate and effective response to the HIV/AIDS crisis in Africa could include collaboration between traditional and biomedical health providers in a European Union–financed research project. We found that practitioners from both sectors seemed willing to strengthen collaboration with each other. However, there were many unsolved challenges and regulatory barriers requiring a substantial policy commitment to address the legislative obstacles. In addition, significant stigma was reported by traditional health providers and this needed to be addressed for an adequate distribution of roles between all partners, including traditional health practitioners.[36,37]

The medical model is very powerful—in its place. However, in the CD context it has a number of limitations.

- It is needs-based rather than asset-based.
- It assumes that clinical expertise is dominant.
- It assumes local trust in the conventional doctor.
- It tends to see the world as a group of individuals, not in a collective manner.
- Power relationships tend not to be explored, although they are central to the consultation.
- CD work is often intensely political, while medicine assumes that it is not political.
- There is a strong ethical base to both the medical model and a community development approach. Both are values driven but often value different things.
- Both see evidence and experience as important and a real driver for change but often prefer different types of evidence for decision making.

There are strong links between a community-oriented approach to health and that of traditional medicine across the developing world. These include

- traditional medicine's strong links to social networks;
- the importance of sustainability both around traditional medicine products and folkloric knowledge;
- the intrinsic link between traditional medicine and cultural belief;
- the fact that traditional medicine is the primary form of healthcare to a large portion of the world's population and usually delivered within the community, making the development of a partnership between CD and traditional medicine important; and,
- most traditional medicine practitioners in the developing world are not formally trained but learn their art within the community.

The World Health Organization (WHO) has presented figures showing that up to 80% of populations in low- and middle-income countries use traditional medicine for primary healthcare.[38]

We also see the relevance of the Feb 2013 Delhi declaration on traditional medicine for the southeast Asian countries,[39] which emphasized the importance of traditional medicine and the support agreed on by the World Health Assembly. An area of particular note is in recognizing the potential for TM in primary care and the desire for harmonization of traditional medicine with the conventional, Western approach and support for increasing community capacity.

Similar commitments were made in the WHO Beijing Declaration on Traditional Medicine made in 2008 by more than 70 member states from both the developed and developing world.[40] This declaration and its six action points also called for a linkage of public health to traditional medicine and harmonization of traditional and conventional medicine as well as recognizing the need for research and communication among all stakeholders.

Integrating insights from medicine, the humanities, ethics, and philosophy in a healthcare model that combines high-tech conventional healthcare with ancient healthcare systems and therapies is clearly a challenge, but one that, in fact, has been recommended by the Director General of the WHO. Doing so is more likely to achieve a pluralistic, accessible, affordable, safe, and effective health system than the current situation of separate and parallel systems.

CONCLUSIONS

Evidence is accumulating that social networks and the communities in which we live have powerful effects on our physical and mental health. It is also becoming clear that it is possible to intervene in a cost-effective way to enhance social networks and empower existing local groups through approaches such as community development.

It seems reasonable to infer from the evidence that community development is likely to have a beneficial impact on health protection; on the resilience of individuals and communities; on health inequalities; and on the responsiveness of public services to local needs. However, there are important gaps in our knowledge, as outlined in Box 5 above, and more research is needed to improve the role of CD in health creation. Nonetheless, we have examples from around the world that communities can be health promoting and that principles are emerging that can help us plan for more effective CD.

This article makes the case for extending this kind of work. This could be done in a number of ways; for instance, altering national policies to make commissioning of CD easier. In wealthy countries, joint funding through local authorities and the health system would be an ideal vehicle, gaining benefit from key health-maintaining sectors. In poorer countries, funding would need to come from other organizations, such as the Untied Nations, WHO, and/or the World Bank.

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While some work is already being done, it needs to be extended with support for more active research in the field. To make funding effective, the principles outlined in Box 3 need to be applied. We suggest a public health framework that incorporates these principles with local implementation at grassroots levels. This would bring together health, local authority influence, and funding with local community groups and local people. Community development could form the basis for a systematized approach with local implementation to better harness the assets of local people and local organizations in promoting health, and more effectively empowering communities to tackle long-term noncommunicable diseases and health inequalities.

We look forward to more experience, more action, and more health improvement using community development as the primary tool.

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