# Title:

The Role of Community Development in Building Critical Health Literacy

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# Abstract:

There is growing international interest in health literacy and the processes by which it can be developed. Critical health literacy, one of the domains of health literacy, shows an affinity with the goals and processes of community development. Critical health literacy represents a cognitive and personal skill set that exists at either individual or community level and which is oriented towards social and political action on factors affecting health. This paper examines the relationship between critical health literacy and community development. Using an illustrative case study it explores the extent to which community development processes were used by a project to build critical health literacy amongst vulnerable populations and communities. The case study demonstrates that in working to build the different elements of critical health literacy processes were used that were typical of community development. These processes included; building self-efficacy and self esteem, participatory and mutual learning techniques, acquisition of technical, practical and emancipatory knowledge, democratic processes of collective decision making, critical questioning, critical awareness raising and conscientization. The paper argues for community development to embrace and advance the concept of critical health literacy in order that; its potential to address inequalities in health can be achieved and to create an opportunity to embed community development more fully within health policy and practice.

# Using Community Development to Build Critical Health Literacy.

**Background:**

Health literacy is a concept that has attracted increased attention in the health sector globally over the last two decades. While different definitions exist, health literacy is typically presented as people’s: *“the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.”* (WHO, 2015). Health literacy has been recognised as a determinant of an individual’s health and is itself determined by a range of other variables such as socio economic status, education level, ethnicity and age (Kickbusch et al, 2013). It contributes to health inequalities because the groups most at risk of limited health literacy are those with the poorest health outcomes (Paasche-Orlow, 2010) and is therefore of interest to practitioners and policy makers internationally.

Central to the debates around health literacy, has been the contribution made by Nutbeam (Nutbeam, 2000), who presented a typology for health literacy consisting of: basic functional health literacy, communicative or interactive health literacy and critical health literacy. Functional health literacy refers to the ability of individuals to access and understand written and numerical information while communicative or interactive health literacy involves the personal skills needed to understand and act on information in a supportive environment such as a school or health centre. Critical health literacy is the third domain distinguished by Nutbeam (2000) as the cognitive and skills development outcomes, which are oriented towards supporting effective social and political action. It is the least well developed and researched domain of Nutbeam’s typology but it points to people having the skills to use information to understand and change the factors that influence their health. An analysis of the specific characteristics of critical health literacy (Sykes *et al*, 2013) shows that by developing critical health literacy, individuals and communities can; become informed about the health issues that may or do affect them, may be motivated and able to

access, manage, understand and critically analyse information on health issues, have the skills to effectively and critically communicate with professionals about health issues and make informed decisions about their own health. Importantly, they will also understand the wider social and political causes of health issues and will be motivated and skilled to act to challenge and campaign for change at a structural level. Individuals and communities with this skill set are therefore important self-managers of their own and society’s health and can become important actors in achieving positive health outcomes and health equity. Of all the domains of health literacy, it is critical, rather than functional, health literacy that will allow individuals and communities to challenge services and policies and tackle the root causes of health inequalities (Cross *et al,* 2017).

Building critical health literacy within communities contributes to individuals having more control over personal decisions and also as a “*set of skills that enables people to participate more actively in political and social decisions affecting their health*” (Wise and Nutbeam, 2015 p24). However, efforts to develop interventions to address low levels of health literacy remain focused on individual functional skills relating to reading health information and are primarily located in clinical settings (D’Eath *et al,* 2012). There are very few documented interventions specifically designed to build critical health literacy and little evaluation or research has been undertaken where interventions do exist (D’Eath *et al,* 2012; Cross *et al,* 2017) Where studies have been published (Gould *et al*, 2010; Mogford *et al*, 2011; Renwick, 2014, McCuaig, *et al,* 2014) there is a focus on building critical health literacy amongst young people in school settings and a number of opportunities and challenges in doing this are identified including a focus on combining reflection and action for health education praxis . The evidence base is, as yet however, too limited to offer clear guidance on effective routes to build critical health literacy.

Dawkins-Moultin et al (2016) argue that the focus on behavior change approaches to developing health literacy has not led to lasting outcomes because of its failure to recognize the positioning of health literacy at the intersection between individual and societal influences. They suggest a commitment to critical pedagogy within interventions would foster a move beyond a focus on cognition and towards agency

and empowerment that would lead to lasting change and would be more consistent with the principles of Nutbeams’ three levels of health literacy. Exploring health literacy from a critical perspective and borrowing from Freire (1993), critical health literacy is embedded within the idea of ‘critical consciousness’ and is about social action for change or as Cross et al identify it; a form of ‘*health conscientization’* (p136). It is, like community development, an emancipatory process through which individuals and communities become aware of issues and inequities, participate in critical dialogue, and become involved in decision-making and action for health (Zarcadoolas *et al,* 2005).

Despite this clear overlap with the principles and goals of community development, critical health literacy is almost entirely absent from the community development literature and debates (Sykes *et al*, 2013). This may be due to the relative immaturity of the concept, a lack of interest in health by the community development field or because of the difficulties of operationalizing critical health literacy. It may also be the case that community development is unintentionally building critical health literacy as part of its work but without recognising the concept or applying the terminology. A closer scrutiny of the relationship with community development could reveal key learning about the processes of development of critical health literacy and also a better understanding of what is meant by community development for health (South, 2015). Exploring the reciprocal benefits of this relationship may, not only help advance the development of critical health literacy but may identify opportunities to embed community development in health practice and policy.

This paper examines the relationship between community development and the concept of critical health literacy through an illustrative case study. The study aims to examine the extent to which community development processes were used by a project to build critical health literacy amongst vulnerable populations and communities in order to tackle inequalities and issues of social justice. In using an illustrative case study, this paper intends to identify and examine processes that could usefully be deployed in the development of projects to build critical health literacy.

# Method.

Case study research is appropriate when exploring questions that require a detailed understanding of social or organisational process (Hartley, 2014) or studies that seek to answer a “how’ or “why” question (Yin, 2014). A case study was therefore deemed appropriate for this study, allowing the opportunity to investigate a particular case in depth and produce rich data that helps in understanding the processes involved in building critical health literacy and the relationship with community development. As an illustrative case study that aimed to illuminate and examine the implementation of processes, this research was not evaluative and did not seek to identify the impact or outcomes of critical health literacy. This is an important area for future research and can be undertaken once more interventions to build critical health literacy have been established.

The case for study was selected through a purposive sampling process. Very few projects that are explicitly designed to build critical health literacy have been documented and none have been identified in the field of community development. However, the attributes being developed by a project can be seen as more important when selecting the case, than the name or language used by the project (Stake, 1995). A sampling process was therefore employed that ensured that a case was chosen that met the two criteria of a) working according to community development principles and practices and b) building the characteristics of critical health literacy. A list of projects in the U.K. that work according to the principles and values of community development was compiled from projects listed by three national umbrella organisations for community development: CDX, Community Development Foundation (both now closed) and the Federation for Community Development Learning. A list of 29 possible projects was identified. The project selected was the one that most closely pursued the characteristics of critical health literacy. This assessment was made through a review of publicly available information regarding the project.

In order to gain a holistic and detailed picture of the processes used to develop critical health literacy, a number of data sources were included. The use of multiple sources of evidence allows for triangulation and corroboration allowing problems of construct

validity to be addressed (Yin, 20014). Sources of data included; documents, interviews, photographs, audio recordings, social media and researcher field notes.

This case was a UK project run by a community development organisation which campaigns to reduce barriers to health and wellbeing. The aim of this project was to create a vision of a better food system for which community members and the wider organisation could campaign. This was based on a position that community members have a right to be involved in deciding what kind of food system they have and that these decisions should not be left to those who hold power.

The project based its approach on a ‘Citizens’ Jury’ model (Crosby et al, 1989). Residents from four disadvantaged local areas in the UK were invited to take part in a programme of eight deliberative meetings called ‘Inquiries’. The Inquiries began with participants identifying and discussing their concerns around food and barriers to healthy eating. These concerns included issues such as lack of access to fresh fruit and vegetables, poor cookery skills and too many fast food outlets in the local area. These concerns were prioritised by the group and a range of external people (known as ‘commentators’) with relevant expertise were invited to speak to the groups about these issues and why they exist. The project attempted to arrange for two commentators, with differing or opposing perspectives, to speak on each issue. This meant that in one session a representative from a large supermarket chain might be speaking alongside a representative from a campaign group against supermarket monopolies. Participants were given an opportunity to prepare and pose questions to these commentators. Towards the end of this process the participants used their learning to develop a series of actions that they wanted to be taken forward locally or as part of a region-wide campaign to achieve change within the local food system.

Finally, a campaign weekend was organised which brought together all of the Inquiries to develop a joint action plan for change.

The project was run as part of a wider community development campaigning organisation and was managed and run by two key members of staff. The project was guided by an ‘Oversight Panel’, whose role it was to oversee the structure and management of the project. This consisted of decision makers and people of influence

in the local area. Also in place was a ‘Stakeholder Group’ made up of other people interested in improving the food system. They were involved in supporting the project at a more practical level.

# Case study findings and their relevance for community development

The case study data showed that the community development project successfully and deliberatively worked to develop each of the six identified characteristics of critical health literacy (Sykes et al, 2013). The data outlined below illustrate the processes by which the project worked to develop each characteristic and explores the relationship and relevance to community development that is revealed.

*Advanced Personal and Social Skills*

One of the characteristics of critical health literacy is that of advanced personal and social skills that enable people to engage in health- enhancing behaviours and dialogues. Data from the case study demonstrated that the development of advanced personal skills was seen as a priority for this project. Clusters of four distinct types of personal skills development emerged. The first related to how participants felt about themselves as individuals including self-esteem, and confidence. The second included those skills that related to participants’ ability to communicate to others. The third skills set related to how participants interact with others and build relationships and the final set included more formal organisation and planning skills.

Key to the ethos of the project was that the participants were valued as experts. They were described as being experts within the food system and in particular in their knowledge of barriers to accessing healthy food, but they were seen as coming to the project with little formal power over the system. The way that participants were valued as experts was seen as being directly related to an increase in their confidence, self worth and self-esteem. Confidence was identified as a theme in numerous pieces of data with many examples cited of participants becoming increasingly willing and able to participate, speak and act within the group. Participants themselves commented on their growing confidence and facilitators described a deliberate strategy of valuing the experiences and views of participants as a mechanism for

increasing their confidence and ultimately their ability to act.

The building of these personal skills and social skills and the increased confidence, self- esteem and self-efficacy that they lead to are key to community development. They are the foundation upon which autonomy and the confidence to act are based (Ledwith 2011) and the building of psychological empowerment amongst individuals has been shown to be a key strategy in building collective empowerment (Wallerstein, 2006). Without such personal autonomy and control, critical participation in society and collective action is weakened (Doyal and Gough, 1991).

*Advanced Information and Analytical Skills*

The critical health literacy characteristic of advanced information and analytical skills can be broken down into a number of more specific skills including; a motivation and ability to acquire health information, the skills to manage that information, understand information, discriminate between sources and assess credibility and finally the skills to critically analyse information.

The project generated a great deal of information for participants and employed a number of strategies to develop participants’ skills in these areas. Exercises were frequently used that involved capturing information and reorganising it into categories or priorities using visual mapping type techniques. Participants had the opportunity to learn specific technical skills related to managing information such as how to do a food audit to capture what different shops were charging for the same food. Such techniques are widely used in participation projects and participatory research and they work to address the address the inequalities in access to resources (Cornwall and Jewkes, 1995). Using such techniques of mutual learning and analysis empowers people as agents who can think critically and investigate their own situations (Holkup, et al 2004), so creating a critical awareness of one’s own situation, an important stage in the Freirean process of conscientisation (Freire, 1971).

*Health Knowledge*

Related to the ability to access, understand and analyse information is the third characteristic of critical health literacy; that of having health knowledge. This theme

includes being informed of, and understanding, health issues, either one issue in particular or health issues in general. This understanding includes having a familiarity with the language and jargon that may accompany different health issues. Increasing health knowledge was a secondary rather than primary aim of the project. However, there were opportunities to increase knowledge about health issues through the contributions of the health commentators.

Learning processes and knowledge generation is central to many community development initiatives. Cranton (2006) uses Habermas’s critical theory to offer a framework of knowledge that drives transformational learning within community development. This includes three types of knowledge; technical, practical and emancipatory. While factual or technical knowledge gain is important, the community development goals of social mobilization and action for change will only be achieved when this type of knowledge is accompanied by the acquisition of emancipatory knowledge (Westoby and Shevellar 2012) which allows for critical reflection on the social and political context. While this case study showed technical learning on issues such as healthy eating, salt content and obesity to have occurred,, this took place within a framework of more emancipatory knowledge acquisition which explored these issues within the social and political contexts of issues such as food labelling, food policy food distribution systems and supermarket power.

*Effective Interaction between Services and Individuals.*

This characteristic relates to the relationship between services and individuals and an ability to interact effectively. This involves an ability to navigate services but beyond this to advocate and articulate oneself confidently when communicating with a health professional and where necessary question or challenge a professional in a constructive way. This level of effective interaction is not only dependent on the skills of the individual but also on the skills of the professional.

The skill set developed through this characteristic of critical health literacy is an example of the acquisition of the second type of knowledge from Habermas’s framework described above; practical knowledge. This form of knowledge is based on

our need to understand each other through the language we use and to recognize the interpretative processes that operate through communication and is significant in effective collective action (Westoby and Shevellar 2012).

The very experience of coming together as part of a community project meant that participants gained an increased awareness of local resources such as the local Healthy Living Centre and the Locality Worker. The use of expert commentators to come and speak to the group was a further route through which participants gained an increased awareness of the services available. Alongside an awareness of services was an increased understanding of what the services do and the systems within which those services operate. One important outcome of this process was that services became more humanised, generating an element of trust.

During the interaction with services, participants were encouraged to develop skills in considering and asking questions. Questioning went beyond asking for information and clarity, to a more critical level. The questioning of motives, credibility and reliability became almost normalised within the group and became part of how the commentators were received.

*Informed decision making*

The fifth characteristic of critical health literacy is the ability to contextualise information, apply it to one’s own situation, judge risk, act on information and thus share the decision making with health professionals. Working with participants to the point where they are able to make informed decisions based on a range of perspectives was a key aim of the project. Having an opportunity and time to reflect on information and explore it with peers occurred both formally and informally. The structured processes implemented by the project meant that participants were taken, as a group, through a staged process of decision making that went from receiving information, identifying recommendations about what should be done, prioritising these recommendations and finally voting on the best course of action. This meant the decision making process was informed and clear but was very much about making decisions at a collective rather than individual level. Democratic processes of collective decision making and their contribution to full citizenship lie at the heart of community

development values (Gilchrist and Taylor, 2011).

*Empowerment and Political Action*

An important characteristic of critical health literacy can be broadly described as empowerment and political action. Within this, a critically health literate individual or community has an understanding of the determinants and the policy context of health, an understanding of opportunities to challenge these determinants and policy and the motivation to act at a political and social level. This reflects the critical awareness that comes from the conscientisation process that form the basis of Freire’s critical pedagogy and which is central to community development. The movement from critical reflection to collective political and social action to address injustices is the core goal of community development and clearly emerges from this characteristic of critical health literacy (Gilchrist and Taylor, 2011).

The project fully embraced these elements and made explicit that its aim was to empower individuals and communities through a programme of community engagement. This sought to address, through action at a political level, inequalities and injustices in health with particular reference to the barriers to healthy eating that exist in disadvantaged communities.

An important part of this process was the consideration of power. The project aims included a commitment to address power imbalances through the community engagement process and activities were undertaken to explore what power was held by different stakeholders. Identifying areas for possible change was a structured process which involved all of the participants. This resulted in a lengthy list of areas which the groups then went on to prioritise through a voting system. The result of this prioritisation process was that a set of recommendations were agreed that the participants wanted to see taken forward. Some of these recommendations were taken on by the campaigning remit of the wider hosting organisation and some were taken on by the community members themselves. Offering a level of on-going support to the participants in implementing changes was seen as important and unique from other deliberative processes.

Numerous examples were given of participants continuing, after the end of the formal project life, to work for change both as a collective and as individuals. Examples ranged from community level initiatives such as the setting up of a food co-op and community cookery classes, to organising petitions, lobbying MPs, and working with local planning departments and takeaway owners. The result was described by project facilitators as a shift from a collective of local individuals to a movement of local activists pushing for change at a local, regional and national level.

*A Learned and Movable state*

This final characteristic of critical health literacy refers to it as an asset that is learned rather than inherent. As such, it represents something that is not static but which can increase or decrease with time and according to different health issues (Sykes et al 2013). The project represented a learning process, as does community development, and was designed to increase the critical health literacy of participants. As such, it represents a position that critical health literacy is learnt and can be developed rather than being inherent.

# Discussion

A critically health literate community is one that has the personal, social, information and analytical skills along with health knowledge, that allows for informed decision making and action around factors that impact on a community’s health and well being (Sykes et al 2013). The sampling processes ensured that the project chosen was one that identified itself as being a community development initiative and indeed from the analysis of the case study it can be seen that its goals are to work collectively and interact with services and decision makers to challenge unjust determinants of health and work towards collective change. In this, it is possible to see a kinship with the goals of community development. Community Development has been described as having an ‘ambiguous nature’ (Craig et al, 2011 p7) but common across definitions is that it is an approach that seeks to achieve greater levels of social justice, with communities themselves identifying issues and priorities and working together towards a collective

solution (Gilchrist and Taylor, 2011; Popple, 2015; IACD, 2016). In developing the characteristics of critical health literacy, this project has pursued these same ambitions.

Not only do their goals align but the processes of community development are also shown by this case study to be relevant in the building of critical health literacy. This project uses participatory and emancipatory processes that echo those of community development of: working to help communities to understand their shared situation through critical consciousness-raising, of developing a questioning approach to their every day situation, of using dialogue to identify the causes of that experience and organising transformative action to address injustices (Gilchrist and Taylor, 2011).

Despite this clear relationship between critical health literacy and community development the project did not use the term critical health literacy. The project workers were aware of the concept and saw their work as being closely aligned to it, but did not use the term. In demonstrating the relevance of the concept to community development the question is why critical health literacy is not explicitly embraced within the field of community development. Nutbeam (2000) in his original presentation of critical health literacy, identified links between health literacy, education and community development, and yet subsequent academic commentary has not referred to community development. Instead, discussions around health literacy have been dominated by a focus on functional interpretations that link low literacy and numeracy with poor health outcomes. The critical and political aspects of health literacy haven’t gained the same currency (Sykes et al, 2013).

Possible explanations for the absence of critical health literacy in community development discourse are that there is too little theoretical basis for critical health literacy to inform the complex pathways of the community development process or simply because the concept is too new. The lack of operationalisation of the concept in any field of practice means that the processes for developing critical health literacy have previously not been closely examined.

A further explanation however, could be the continued silo-mentality that exists

around health and health care and community development’s limited engagement with the health sector. Despite attempts at a local and national policy level to encourage cross sector working (Baggott, 2010) the tendency to see health as a “*narrowly defined organisational and policy sector”* (Hunter, 2008, p173) remains dominant. Community development, despite its contribution to health outcomes (Gregson and Court, 2010; Woodall *et al*, 2010; HELP, 2011; Eden and Lowndes, 2013), has been used most commonly by Local Authority and voluntary agencies but has far weaker links with the health sector (Chanan, 2013). Chanan argues that where it has been used by the health sector, it has often been regarded as a “*marginal public health technique”* (Chanan, 2013, p3). Where community development has found a place in health policy, for example under the Labour Government 1997-2010, where a host of community based health policies and initiatives were enacted, concern was raised that this undermined the true and radical element of community development. This, some claim, resulted in government delivered through communities rather than government delivered by communities making community development simply an arm of policy implementations (Shaw, 2005).

It is also possible that critical health literacy has not found a place within community development because of its overlap with concepts that are already established in the field. Health activism, for example, which involves action on a particular health cause (Laverack, 2013) may well share many of the characteristics of critical health literacy, particularly around political action on health issues such as access to anti retroviral treatment or mental health services. However, critical health literacy is a unique concept formed of a distinct set of characteristics (Chinn, 2011). It places a premium on information and analytical skills and these are not highlighted in definitions of activism.

Despite the challenges facing the operationalisation of critical health literacy within the field of community development or elsewhere, explicit attempts to build critical health literacy could offer an important strategy for addressing key public health issues. Obesity, for example, is commonly addressed by behaviour change or through top down structural changes such as taxation. A focus on advanced information skills and a collective understanding of the determinants of obesity could be empowering

for communities and result in transformative action for change. This can be seen in the case study described and in other community led initiatives such as the Mountains against Macdonalds group’s action in the Blue Hills in Australia (McIntyre, 2013). Such action has the potential to form the basis of positive health outcomes and when undertaken amongst those communities experiencing inequalities can offer opportunities for their voices to be heard and for social injustices to be challenged.

Encouraging the field of community development to embrace the concept of critical health literacy could create a route for working more closely with the health sector. Community development is a field that is well used to falling in and out of favour amongst policy makers (Shaw, 2011) and Popple (2015) is confident that community development is well able to continue its vital work outside the direct remit of the state. However, current economic pressures result in serious implications for the field not least following the closure of the Community Development Foundation after fifty years as a public body (Pavee Point, 2013; Crowley, 2012). The field of community development in the UK has made a recent co-ordinated effort to be more fully recognised and utilised by the health sector. A Charter for Community Development (NHS Alliance 2014), developed under the umbrella of the NHS Alliance and Health Empowerment Leverage Project, formally called on national and local health bodies to use community development to improve health outcomes. Community development is explicitly identified as a competence for community health workers (PHE, 2016) and Public Health England calls for place-based approaches that draw on all the assets and resources of an area and builds resilience of communities in order to improve health and wellbeing for all and to reduce health inequalities (South, 2015).

Embracing and making explicit a link to the health literacy agenda through the development of critical health literacy could provide a useful entry point for community development into health. Critical health literacy exists within the large and established health literacy movement (WHO 2016). By embracing critical health literacy, community development could potentially draw on the political will and capital that has been championed by the movement. The explicit element of empowerment and political action within critical health literacy would, at the same

time, ensure that this could be pursued while respecting the call to maintain the radical roots of community development (Ledwith, 2015).

Finally, a commitment to using community development to achieve the Sustainable Development Goals (SDGs) (United Nations, 2015) has become central to the current community development dialogue (Howard and Wheeler, 2015a). The International Association for Community Development state that without community development there is no sustainable development (IACD 2016) and community development is called on to engage with the SDGs to ensure they are truly transformative for those living in greatest poverty (Howard and Wheeler, 2015b). In responding to this call, attention needs to be paid to the third SDG; “ensuring health and sustainable health and well being for all”. In considering how community development can best to work towards this, it should be noted that strengthening health literacy has been proposed by WHO (2016) as one of three priority action areas for health promotion to achieve this goal. This then offers a further reason for community development to consider the relevance of critical health literacy to the field.

The use of an illustrative case study has offered the opportunity to examine in detail the processes used in developing each of the characteristics of critical health literacy. This provided a practice based example from which to explore the broader community development theories and the insight they offer in understanding the potential role community development has to play in advancing critical health literacy . While a single rather than multiple case study approach was chosen, this allowed for the depth of analysis required to explore the complex process involved in delivering this project. A challenge of case study research is identifying an appropriate case (Yin, 2014) and this was a particular challenge for this research for the reasons already discussed. One limitation of this research was that the chosen project had the development of health knowledge as a secondary rather than primary aim. However, the likelihood of finding a project that prioritised the development of all the critical health literacy characteristics was unlikely given the limited number of interventions documented.

Despite the development of health knowledge being a secondary objective, there was sufficient attention given to this characteristic to extrapolate learning for future

interventions.

# Conclusion

Building critical health literacy skills amongst individuals and communities could increase community influence over a range of determinants of health. However, the lack of initiatives to build the concept means that this potential cannot be assessed. This illustrative case study shows a strong affinity between the goals and processes of community development and the characteristics of critical health literacy and yet the concept has not found its way into the dialogue or practice of the field. It may be that the lack of operationalisation of critical health literacy is because it has not yet found its natural home and remains within the functionally focused arena of health. A more explicit adoption of the concept by the field of community development, may however offer it the opportunity to realize its potential.

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