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6 Using theory to guide change at the community level

Morten Skovdal

Overview

Those concerned with health promotion tend to target their efforts at various levels, from global, national and regional levels down to community and individual levels. Each level is important and health promotion practitioners should look to harmonise these multi-level efforts. The community is the cross-roads between these levels. Communities translate health promotion messages and promote social cohesion – shaping our lived experiences and the way we conduct ourselves, including our health behaviours. Understanding how to engage with local communities to provide more health-enabling social environments is therefore key to health promotion theory. For these reasons, this chapter focuses on the health promoting role of the community as a pathway for change.

Learning objectives

After working through this chapter you will be able to:

- **explain the relevance and role of community level structures in promoting health**
- **draw on conceptual perspectives to understand how health promoters can help guide change at a community level for improved health**
- **identify ways to better integrate health programmes into a social context and facilitate community responses for health**

Key terms

Community capacity building Enabling people in communities to participate in actions based on community interests.

Community health competence The degree to which a community is health-enabling and responsive.

Community response - The combination of actions and steps taken by community members for the public good, including the provision of goods and services.

Conscientisation The development of a critical consciousness, a better understanding of the inequalities that exist in the world, particular in relation to self.

Participatory learning and action An approach for learning about and engaging with communities using participatory and visual methods to facilitate a process of collective learning and action.

Salutogenesis An approach focusing on factors that support human health and well-being, rather than on factors that cause disease.

Social capital The social benefits that derive from social networks and collaboration between people, and their shared values and norms of behaviour.

Introduction

As Section 1 of this book explored, the 1986 *Ottawa Charter* built on the *Alma Ata Declaration* and the *Health for All* philosophy by redefining the field of health promotion. It did so by encouraging a shift away from a focus on the modification of individuals and their health-damaging behaviours to recognising the importance of the social environment in shaping and determining health actions. This is because an individual's decision to engage in health-damaging behaviours, such as smoking or refusing to use a condom, are not necessarily determined by rational thinking of the risk factors, even if the knowledge is there. Instead they are influenced by the extent to which the social environment supports, or even encourages, such behaviours (Campbell, 2001). Individuals do not live in a vacuum but in social and community contexts that have the potential to enable, or inhibit, health-enhancing behaviours. This is a paradigm shift that has changed the role of health promoters working at a community level. Health promotion at a community level is no longer about 'experts' providing target audiences with health-related information, but is about engaging with local actors to challenge health-damaging practices and norms as well as to facilitate locally defined solutions to health problems. However, a real shift has been slow because didactic and information-based health promotion methods are relatively straight forward and easy to get off the ground compared with engagement and facilitation approaches. Furthermore, there is limited understanding of theories guiding change at a community level.

What do we mean by community level?

Health promotion practitioners working at a community level are faced with the challenge of having to define what is meant by community in the context in which they work. Often community refers to a geographically bounded area, a neighbourhood or a village. Whilst this is a relatively simple understanding of community, it gets more complicated when the definition is expanded to include members who share a common social identification. This understanding of community recognises that individuals belong to a number of communities, both within a geographical area and beyond, each of which can play a health enabling or inhibiting role. A community of identity may include a group of people who share a set of beliefs and history (for example a religious community); a sexual identity (for example gay men); experiences of marginalisation and

discrimination (for example people living with a stigmatised disease); hobbies and interests (for example a sports club, or online gamers forming a virtual community) or a a common purpose which collectively they work towards (for example women's groups). These and other social groupings form communities of people with common experiences, interests or beliefs. People are likely to actively participate in and draw on the benefits of a number of different social groupings at any one time. How these communities are experienced, as well as their significance on health, differ significantly and may come down to the nature of the social interaction that binds people together.

Activity 6.1

Activity: This activity encourages you to reflect on the diversity of community. What communities are you a part of? Make a list of all the communities you think you belong to. Think about what qualifies you to be a member of these communities and how each of those communities plays a role in facilitating your health and well-being.

Feedback

Your examples will show how diverse communities are, how they overlap and how they influence behaviour.

Although the internet has enabled social interaction to transcend beyond the locality of people, most social interaction still takes place in local social environments, and as such, the spatial dimension of community remains significant. Community level in this chapter therefore refers to the local social environment where norms, local institutions and social interaction (often in 'communities of identity') mediate responses to health.

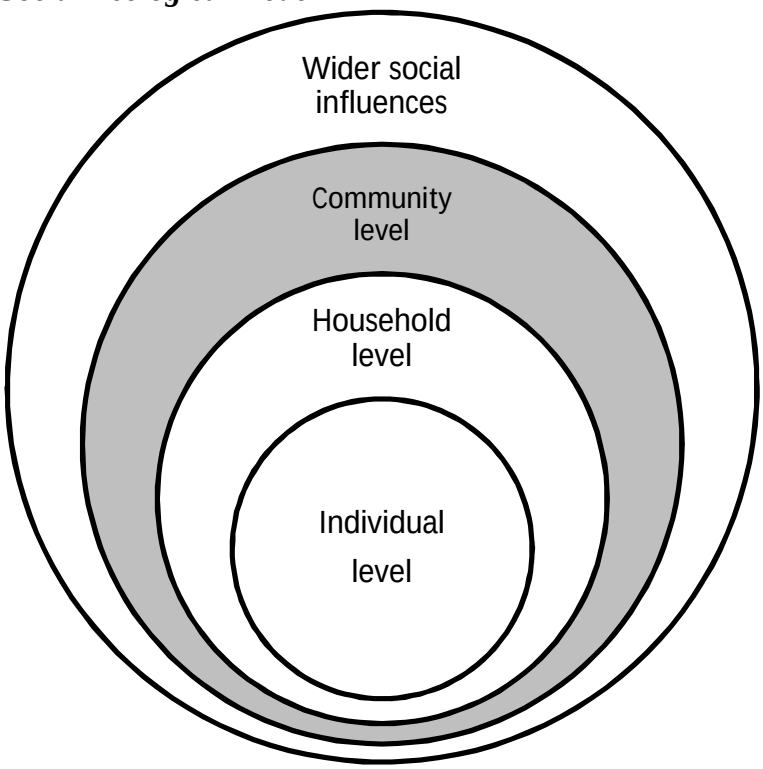
Health-enabling social environments

As discussed in Section 1 of this book, the field of health promotion has moved beyond a focus on individual behaviour and recognises the importance of a wide range of social and environmental interventions. The role of community level health promoters is therefore to facilitate the process of health-enabling social environments, where people are in a position to take control over, and improve their own health and that of others. Consequently community participation and empowerment are key to community health promotion. Before discussing theories that can guide change at a community level, it is useful to describe some of the social structures, actors and contexts that are part of a health-enabling social environment and thus play a key facilitating or inhibiting role in health promotion at a community level.

A model often used in the field of health promotion to discuss pathways to more health-enabling social environments, and the interplay between social structures, is the Social Ecological model (Bronfenbrenner, 1979; Stokols, 1996). The model, as illustrated in Figure 6.1, usefully situates the community within a broader and vertical context,

locating the community at the intersection between individuals and their immediate family and wider socio-political and cultural factors, thus playing a key role in mediating initiatives for improved health. What the model highlights is that changes at a community level are interdependent on wider social influences. Empowerment and health-enabling behaviours do not happen in a vacuum. More specifically, contexts enable, and in some cases inhibit, the effectiveness of community level responses to health promotion. This means it is essential to consider wider social influences in community level health promotion. These contexts include: the availability of material (for example, condoms orsustained funding from global actors);symbolic factors (for example, social policies being aligned with local realities or gender constructions):relational issues (for example, patient/nurse relationships, level of community involvement); and institutional factors (for example, the quality and availability of health services) (Campbell and Cornish, 2010; Skovdal, Campbell et al., 2011).

Figure 6.1: Social Ecological model



Adapted from Bronfenbrenner, 1979

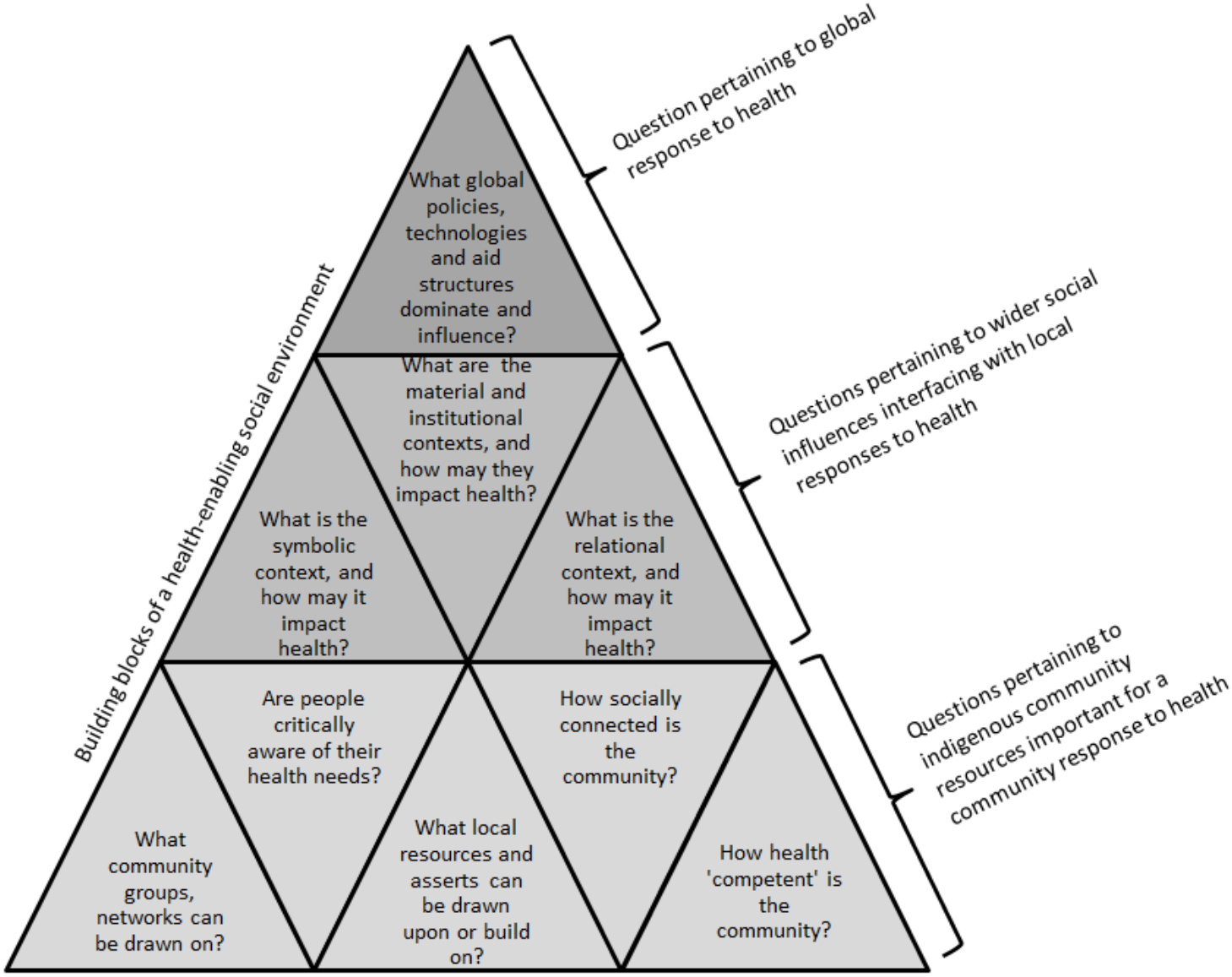
Nonetheless, it is at a community level that health promotion initiatives take shape and get appropriated to local realities. It is at a community level where identities are created as well as where social knowledge, shared meanings and common values get enacted – with the capacity to influence health-related behaviours both positively and negatively. It is at a community level where health-related behaviours are learned and practiced, affirming the intrinsically social connection to health.

Playing an active role in shaping these norms, values and health-related behaviours are smaller level and interdependent social structures horizontally nested within the community level. These social structures make up tangible actors, representing a mix of external change agents, such as local non-governmental organisations, local government departments, schools and churches and indigenous community groups, networks and other 'communities of identity'. Learning how to engage with and empower these social structures are pivotal to community level health promotion.

The field of health promotion is dominated by formal responses that enable people to take control over, and to improve, their health. Here, health promotion initiatives, spearheaded by more technical and resourceful organisations, involve community members in their programme design and implementation. Whilst this continues to be important and integral to health promotion initiatives, there is, however, also a need to acknowledge that most responses to health continue to be led by local community groups and networks, often with no support from external change agents. This is particularly the case in countries where health care is not a public good. This can be exemplified by the community response to HIV in Africa. Here indigenous community resources (such as community norms, networks, connectedness, assets, critical consciousness and opportunities for dialogue) have been observed to, though not always, provide significant 'behind the scenes' support for those living with or affected by HIV (Campbell, Scott et al., 2013; in press; Gregson, Nyamukapa et al., 2013; in press). Indigenous community responses can therefore have a positive impact on behaviour change and much can be learned from them to strengthen and align more formal community level health promotion initiatives with local resources. A recognition of indigenous community responses also open up for the opportunity for health promotion to not only be about enabling individuals to take control over their health, but also to be about enabling community members to play a role in improving the health of others.

Against this background, to facilitate effective health-enabling social environments, health promoters working at a community level must recognise and bridge local *and* global structures responding to health, establishing dialogue between local community members and global actors penetrating local communities. Health promoters working at a community-level must serve as mediators and make every effort to understand the context in which they work and identify key actors and contextual factors facilitating or inhibiting health and well-being. Health promoters can use this information to work with local community structures to devise a strategy that establishes productive alliances that can work towards the building of health-enabling social environments. Echoing the above, Figure 6.2 details a pyramid that outlines some of questions that health promoters working at a community level can ask to gain a better understanding of the social structures, factors and contexts that impact change at a community level. This information can be used to identify pathways towards a more health-enabling social environment and can inform a theory of change.

Figure 6.2: Questions to consider when developing a community level health promotion strategy



Why do we need theory of change?

Theories of change help us unpack pathways to change. They are often advanced by social scientists and applied by practitioners. They make explicit the role of health promoters and uncover the thinking and beliefs that guide our assumptions of how interventions can make an impact. A theory of change articulates what activities have to happen for an expected change to happen. Put simply, by doing x (an action), y (a change) will be achieved. Needless to say, no social change initiative is that straight forward, and most mature theories of change are made up of systematically organised

knowledge that provide you with a comprehensive road map to consider the populations you are serving, and help you establish the broader context and other major factors influencing change. Mapping out the preconditions influencing pathways to change can help circumvent failure and optimise the impact of a health promotion strategy.

Moreover, a theory of change can crystallise the intended results of a social change initiative and that way help practitioners plan and develop health promotion strategies that can be evaluated. A theory of change can thus become a useful tool in demonstrating success and lessons learned.

Activity 6.2

Activity: In this activity you will analyse how theories of change apply in practice. In rural Zimbabwe, some men fail to make use of HIV testing and treatment services. Local understandings of what it means to be a 'real man' appear to be in conflict with the expectations of users of HIV services. For example, some men in parts of rural Zimbabwe do not want to accept that they are vulnerable and at risk of contracting HIV, and those living with HIV are given lessons (often by female nurses) on how to live healthily, requesting them to stop engaging in certain activities (such as drinking alcohol and extramarital sex) which some men participate in to project and exert their masculinity (Skovdal, Campbell et al., 2011). Against your interest to improve HIV service use by men in this context, develop your own theory of change by asking the following two questions:

1. What change would you like to see happen so that men in this context are more likely to make use of HIV services?
2. What must happen in this context for your change to be realized?

Feedback

Your change should be plausible and focus on changes in and between people and groups that a social change initiative can realistically tackle, for example, make men feel more at ease with HIV and HIV services. Your vision should not point to an idealised and unachievable state such as transforming local understandings of masculinity. Your vision should be dynamic, and reflect the complexity of the social structures in which the initiative would be located.

Your actions, or pre-conditions for change, can either consist of tangible changes (for example male friendly HIV services such as men only clinics, male nurses, peer support groups for men) or process outcomes (for example attitude changes, more lenient and flexible understandings of masculinity, supportive relationships and confidence as a result of community conversations, peer group meetings or community role models discussing the impact of masculinity on HIV service use).

In the field of health promotion there is growing recognition of the need to learn from pathways to achievement and health as a way to guide theories of change. For example, a theory of change to address men's inclination to uses HIV services could be strengthened from knowing how some men manage to construct HIV-service friendly masculinities and successfully adhere to antiretroviral therapy without feeling social pressure to conform to hegemonic and local understandings of manhood.

Conceptual perspectives and theories guiding change at a community level

There are a host of theories and conceptual frameworks that seek to explain, predict and change pathways towards more health-enabling social environments. In this section you will learn about four key conceptual perspectives that will advance your understanding of possibilities for change at a community-level.

Critical consciousness and collective action

Collective action for change does not happen overnight. It is a result of a growing critical awareness of a social or health problem and recognition of the need to come together and instigate change. The writings of Brazilian educator, Paulo Freire (1970; Freire, 1973), can help us understand why developing a critical consciousness is important to spark collective action and change, as well as how this is achieved.

To do this, Freire uses the example of didactic and top-down teaching, a pedagogical approach adopted in many parts of the world, to argue that such an approach to teaching assumes learners as passive beings in need of controlled knowledge, failing to foster critical thinking, and serves the purpose of keeping the rich and the elite in power and to further oppress the poor and powerless. Freire therefore calls for an alternative approach to teaching, one where learners and teachers engage in dialogue as equals, making the learners integral to the learning process, as opposed to objects. For Freire, education should be about creating safe social spaces for dialogue to occur, allowing people to share their life experiences and as a collective, and individually, develop ideas, new understandings and ultimately a more critical awareness of self and other. Critical thinking, Freire (1973) argues, evolves over a series of stages, starting with 'intransitive thought'. At this stage people do not see it as within their power and control to instigate change and improve their life situation. If change does happen, this is likely to be explained by the influence of wider social structures, and even luck. The next stage towards more critical thinking pertains to 'semi-transitive' thought. Here people begin to see the connection between their actions and change to their lived realities, and experiment with various actions to instigate change. At this stage however, they may still struggle to connect their social problems with the wider social structures and determinants that impact their lives. The final stage Freire refers to as 'critical transitivity'. At this stage people are experiencing an awakening of critical consciousness, or *conscientização* as Freire called it, and are able to critically engage

with their life situation and see the connection between their social problems, or poor health, and the structural violence, oppression and social inequalities that keep them in this condition. This will spark their interest to instigate change.

In summary, the change theory of this conceptual perspective is that creating social spaces for reflection and critical dialogue is a vehicle towards a more critical consciousness, where people become critically aware of their social situation as well as empowered, increasing the likelihood, and their interest, to translate this awareness into collective action and thereby instigate change.

A strength of this theoretical exposition is that it highlights the importance of seeing development as a process, involving a partnership between both those with more or less power. The theory can be used by health promoters to reflect on how they engage with people at a community level to build their critical awareness of health matters to instigate change. Photovoice, a health promotion tool rooted in Freire's conscientisation theory, is described later in this chapter as one potential tool to facilitate community level change.

A limitation of the theory is that it fails to fully recognise the importance of 'awakened' people or communities to build partnerships with more resourceful actors such as health promoters. People and communities may for example be fully aware of the health implications of drinking water from a water hole also used by livestock, but do not have the resources and means to build a fencing system and water troughs, or money for transport to go and lobby for change. Critical awareness is a prerequisite for community level change, but we should not assume that this automatically translates into change and collective action.

Community participation

Although community participation more often occurs naturally and through indigenous social networks and groups – and from which much can be learnt – the focus here is on the role of health promoters in drawing on the concept of community participation to facilitate more health-enabling social environments. Community participation is a central tenant to health promotion. It is widely accepted that only when externally facilitated health programmes recognise and draw on local structures and ways of life will they resonate with local needs, be relevant and contribute to changes in health-related behaviours and an effective community response to health. As a concept, community participation is a minefield, with its meaning always being contextual and partial, reflecting varying understandings and commitments to the term. Community participation can for example take different forms and reflect different degrees of community involvement. Peter Oakley (1991) distinguishes between three types of participation:

- *Participation as a free resource* – Community members may be invited to get involved in a project, implementing activities. This kind of participation is often marginal and primarily involves community members in order to tap into community resources (e.g., labour, land, knowledge, time). This kind of participation does not seek to empower or appropriate a health promotion initiative to local needs, but is used to meet externally designed programme goals and to use community members as a free resource. For example, unpaid community health workers trained by an external change agent to improve the hygiene and hand washing practices of community members in a rural community might spend hours trekking from household to household talk to them about their hand washing practices.

- *Participation as consultation* – In this type of participation community members may be asked about their priorities, possible solutions to a local health need as well as their level of involvement in the programme. The external change agent will however still retain control over the aim of the programme and the kind of activities that will be implemented. For example, a health promotion initiative looking to reduce HIV transmission amongst sex workers might consult sex workers about their sexual health needs and learn that they want improved condom access and sexual health education by peer educators. The external change agent might improve condom access, train peer educators and have them facilitate the sexual health education, but may decide to only improve condom access if that was the prearranged aim.

- *Participation as community control* – This level of participation allows community members to have complete control of the health initiative. For example, a sex workers' network may be mobilised as part of a health promotion initiative. But rather than having a set of prescribed project goals and activities imposed upon them, they conduct a needs assessment of their health needs, develop solutions, carry out activities and evaluate progress. In other words, community members play an integral role in implementing the health promotion initiative, from start to finish.

Whilst there is a role for all three levels of participation, depending on the context, community-level health promotion initiatives ought to strive for participation as community control. There are a number of reasons for this. Aside from appropriating and contextualising a health promotion initiative, ensuring there is a good fit with local needs, community control of the planning and design of health promotion initiatives ensures community members are more likely to get involved and stay committed to the long-term goals of the initiative. Barriers to health can also be more easily identified and addressed, optimising the impact of health promotion initiatives. But more importantly, participation as community control recognises participation as a process as opposed to an activity used to achieve a single health outcome. Reflecting Freire's theory of *conscientisation*, the process of community members conducting a needs assessment, gathering and analysing

information about local health needs improves their consciousness, making it easier for them, as a community, to transform and negotiate new and more health-enabling norms and behaviours. Furthermore, the participatory process of community-led project cycles can be empowering, and ensures the participation and commitment of community members to the programme in the long term. Their experiences of taking an active role in the implementation of a programme can facilitate a sense of worthiness, enhance their internal locus of control and self-efficacy as well as a positive social orientation (Skovdal, Mwasiaji et al., 2011). Participatory programmes can also improve individual and collective problem-solving abilities, improve social relationships and give them hope for the future. These are only some of the many social psychological outcomes that participatory processes may facilitate and represent protective processes that are of great value in enhancing the resilience of individuals and communities (Rutter,1987).

In summary, the change theory of this conceptual perspective is that creating opportunities for community participation can, if done meaningfully and with community members taking an active and direct role in implementing a health promotion initiative, facilitate an educational process and dialogue that can help communities transform attitudes, norms and actions that are health-damaging into more health-enhancing lifestyles. Community participation can also be empowering, and in the vein of *conscientisation,* give people the chance to take control over different aspects of their lives, including their health.

A key strength of community participation as a conceptual tool in health promotion is that it is endorsed by global health policies, particularly in the wake of the *Alma Ata Declaration* in 1977. As a result, community participation is widely recognised to be a key pillar in any health and development initiative, which makes it easier for practitioners at a community level to promote community participation for improved health.

A limitation of community participation is that the meaning of 'community' and 'participation' varies between people and over time. The boundaries of communities are fluid and constantly shift, and participation can range from being merely a free resource to encompass community control. Participatory community health promotion programmes can also easily be hijacked by more powerful individuals, both at local and global levels, to serve their own interests and undermine the participatory process (Cooke and Kothari, 2001). Another limitation pertains to the difficulty of measuring and evaluating community participation. The Spidergram, a tool developed by Susan Rifkin and colleagues to measure the participatory process, is described later in this chapter as one potential tool to facilitate and evaluate community level change.

Social Capital

Social capital refers to the glue that brings people and different actors together for the common good. The term was popularised by Robert Putnam in the 1990s. He defines social capital as the community cohesion that results from "networks, norms and social

ties that facilitate coordination and cooperation for mutual benefit" (Putnam, 1995: 67). More specifically, communities with high levels of social capital are characterised by having a high number of active community organisations and networks, strong commitments to civic engagement or participation within these networks, as well as an ethics of care and reciprocal support, and a sense of solidarity and trust between community members. Although Putnam used the term to describe the socioeconomic and political implications of declines in social capital, a growing body of evidence suggests that communities characterised by high levels of social capital are more likely to be healthy and engage in health-enhancing activities. As a result, a key aim of health promoters working at a community level is to facilitate the development of social capital.

Social capital theory very much builds on the two previous conceptual perspectives. In fact, conscientisation and community participation contribute to the development of social capital, in so far as they seek to create a context where people can come together and take control over their health by transforming health-damaging behaviours and social identities. In the context of health promotion, and the previous discussion on health-enabling social environments, it is useful to unpack social capital and discuss the concept from three different perspectives: bonding, bridging and linking social capital (Szreter and Woolcock, 2004).

Bonding social capital refers to the trust and quality of co-operative social relations that exist between members of a network or community, where members share similar characteristics. This could span from a little women's group made up of elderly widowed women who have come together to deal with hardship and the care and support of orphaned children, right through to the collective response by a village or community to fight off tsetse flies and sleeping sickness. *Bridging* social capital on the other hand refers to horizontal relations of respect and empathy between people, groups or networks whose backgrounds are different, because of factors such as religious beliefs, viewpoints, age, ethnicity, sexuality and social class. For example, in a low-resource and high HIV prevalent community, a church group and an AIDS support group might decide to come together and create a synergy to reduce HIV-related stigma in the community. *Linking* social capital refers to the bridging of relations of trust and respect between people, networks and organisations whereby they interact vertically across power and authority structures. For example, a youth theatre group established to communicate HIV prevention messages may link up with a more resourceful NGO that can provide the group with the resources it requires to move around and reach a large number of people.

In summary, the change theory of social capital is that strengthening the connections between individuals, groups and organisations (bonding, bridging and linking social capital) equips community contexts with an asset that makes them stronger in times of hardship and which can be leveraged to maintain or improve health and well-being.

According to Szreter & Woolcock (2004), a strength of social capital theory is that it acknowledges the importance of recognising the quality and quantity of social relations

between individuals, groups and organisations influencing health. The theory also encourages emphasis on whether or not these social relationships are characterised by mutual respect or differentiated by social identities (horizontal bridges) and their access to power or authority (vertical links).

A limitation pertains to the controversy and criticism that surrounds the theory of social capital. Like community participation, concerns have been raised about the ambiguity of social capital and fears that social capital can be used to justify a withdrawal of government welfare services, with the explanation that communities with high levels of social capital have the power to fulfil this social welfare role (Labonte 1999). Furthermore, social capital does not always carry with it positive health implications. A rural African community may for example avail support to the sick and elderly in many different ways and exhibit high levels of social capital for those who conform to the status quo of community life. Whilst this is beneficial to the majority of community members, narrowly conscribed networks can simultaneously reject more stigmatised groups, such as men who have sex with men, leaving them extremely marginalised and vulnerable.

The asset model

Traditional health promotion models tend to focus on epidemiological risk factors, for example smoking, poor diet and lack of exercise. In doing so they take a deficit approach by focusing on gaps in services, information and capacity. By contrast, the asset model looks at the resources of individuals and communities and how these can be harnessed to improve health and wellbeing. These resources or 'health assets' are defined as any factors which maximize opportunities for individuals and local communities to acquire, maintain and sustain health and well-being (Ziglio, Morgan et al., 2013).

Health assets can include factors from across the range of the determinants of health, including genetic make-up, economic and social conditions, environmental conditions, health behaviour and use of health and other services. Research by the WHO European Office for Investment in Health and Development (Harrison, Ziglio et al., 2004) identified key health assets to include family and friendship networks, intergenerational solidarity, community cohesion, environmental resources necessary for promoting physical, mental and social health, employment security and opportunities for voluntary service, affinity groups (such as mutual aid), religious tolerance and harmony, life-long learning, safe and pleasant housing, political democracy and participation opportunities, social justice and enhancing equity. The assets for health that are amenable to action are often located at the community level so an asset based approach is closely aligned with community development.

Three concepts are central to the asset model. Firstly, the concept of salutogenesis, introduced by Aaron Antonovsky in 1979, focuses attention on health generation as

compared to a pathogenesis focus on disease prevention. Salutogenesis emphasizes the success rather than the failure of individuals by exploring why some people prosper and others fall ill in similar situations (Antonovsky, 1979; Antonovsky, 1987; Antonovsky, 1996). Secondly, the asset model sees resilience as a protective factor for both individuals and communities to thrive, even in the face of difficult circumstances. Thirdly, the model sees the concept of social capital, as discussed above, as key to creating strong supportive networks for health, wellbeing and development.
The asset model suggests that individuals and communities can develop health assets at various stages of life and can use these to offset risks that they face as they age and at critical moments during their life, such as early childhood, entering the labour market, parenthood, sickness, job loss and old age. The model argues there are core sets of assets, linked to the concepts of salutogenesis, resilience and social capital, that are key for the successful transition through these stages. It also recognises that particular assets will impact in different ways dependent on individual circumstances. The model suggests understanding which asset or combination of assets are most important at key transitional stages can help develop more effective programmes to improve wellbeing and health. Ziglio et al. (2013) have defined the following features as key to the asset model:

1. It fosters a systematic approach to developing a coherent evidence base for positive approaches to health and development following the principles of evidence based public health.
2. It emphasises those health promoting and protective factors ('health assets') which can support the creation of the conditions required for acquiring, maintaining and sustaining health and wellbeing
3. It highlights the potential for a set of key theories, methods and actions that can be employed to develop asset based policy, research and practice.
4. It recognises that many of the key assets for health creation lie within the social context of people's lives and therefore offers the opportunity of contributing to the health inequity agenda.
5. It assumes that in order to maximise the opportunity for identifying health assets, that individuals and communities are involved in all aspects of the health development process
6. It is about working with what communities already have, rather than assuming there is nothing there to start with. In this way, it encourages individuals and communities to be active partners in the process, rather than passive recipients
7. It emphasises the importance of a life course approach to the promotion of health recognising that different assets may be more or less important at key life stages
8. It is does not preclude the need to employ the well developed deficit approaches to health, but offers a model that may work synergistically to sustain health and minimise inequities.
9. It ensures existing resources at the individual, community, or organisational level are taken into account.
10. It looks to the individual with their formal and informal associations within the community to create solutions and mobilise capacity to achieve better health.

There are many overlaps between the four conceptual perspectives discussed above. They all build on each other and are rooted in a common recognition of the need to draw on local strengths in creating health-enabling social environments and promote a development process where gradients of power and authority are more aligned and characterised by mutual respect.

Activity 6.3

Activity: In this activity you will consider the role of communities in theories of change. What changes would you like to make to the theory of change you developed in the previous activity to incorporate the four conceptual perspectives you have just been introduced to?

Feedback
Your theory of change should not only reflect an understanding of one or a hybrid of the conceptual frameworks explained above, but also a broader recognition of the steps in the process of change and your role as a change agent.

Tools to facilitate community level change

The conceptual perspectives discussed above highlight the importance of community engagement and empowerment in guiding change at a community level for improved health. There are a number of different participatory learning and action tools that can be employed to facilitate such a process. Participatory learning and action tools seek to visually generate different forms of information, which can then be used by community members to reflect, engage in dialogue and make collective and democratic decisions. Maps, diagrams, pictures and charts can all be used by community members to visually represent information gathered from their local context, whilst ranking and scoring tools can be used to facilitate decision making processes in a democratic manner.

The following two examples illustrate techniques that can be used to apply the theories of change described above in practice. Additional detailed examples of many of the tools that can be used to engage communities are provided in Rifkin and Pridmore's book *Partners in Planning: Information, Participation and Empowerment* and *Tools together now: 100 participatory tools to mobilise communities for HIV/AIDS*, available on the worldwide web from the International HIV/AIDS alliance.

Example 1: Photovoice

Photovoice is a technique that enables community members to visually represent aspects of community life through picture taking. The pictures can be used to reflect on community's strengths and problems as well as a mean to share this information with

fellow community members, health service providers or policy actors (Wang, Yi et al. 1998). In doing so, Photovoice can act as a bridge between local realities and expert priorities, sharpening policy and practice for a better fit with local needs. Photovoice can also cultivate critical dialogue and reflection at a local level, which can instigate cognitive-emotional reactions leading to individual or collective change. In essence, Photovoice stimulates a sharing of information, across languages, literacy and power hierarchies in the hope that this can lead to more aligned knowledge systems and priorities, appropriating community responses, programmes and policies for health.

Photovoice is flexible tool and needs to be adapted to each context. In the field of health promotion, Photovoice is often used as an assessment tool, both in the planning and evaluation of health promotion initiatives. The implementation process can take multiple forms. Below is an outline of key steps that can help you get started.

Photovoice implementation steps (adapted from Wang 2006)

1. **Recruit a group of Photovoice participants**
    - 7-15 people is an ideal size (more have often been used).
    - You can recruit through educational establishments, church, profit/non-profit organisations.
    - If you recruit different groups (e.g. youth/adults, employers/employees, men/women) you can gain comparative perspectives.

2. **Introduce the Photovoice methodology to participants and discuss the use of cameras, power and ethics**
    - E.g. discuss: What is an acceptable way to approach someone to take their picture? Can you take pictures of other people without their knowledge? When would you not want to have your picture taken? To whom might you wish to give the photographs? And what might be the implications?

3. **Obtain informed consent**
    - Put emphasis on the safety, authority and responsibility of using a camera.
    - Consider the vulnerability of the photographer; include a statement of potential risks.
    - Clarify the voluntary nature of their participation, freedom to withdraw at any time without giving a reason.
    - No photographs identifying specific individuals should be released without separate written consent.
    - Obtain informed consent from parents or guardians for all minors.

4. **Pose initial themes for taking pictures**
    - Participants can generate, or be given, specific open-ended questions that will guide the taking of pictures.

5. **Distribute cameras to participants**
    - Decide on using disposable or digital cameras and practice their use.
    - Agree on a time for participants to return the cameras/images for developing/print
    - 1-5 weeks per roll of film is recommended before meeting up again (this process has on occasions been repeated for up to 12 months).
    - Agree on a time for participants to discuss the photographs/write reflections.

6. **Discuss photographs and identify themes**
    - Discuss photographs, or a selection based on a prescribed criterion or based on what the participants find most significant or like the most.
    - Facilitate a group discussion, asking them to describe the photographs, explain what is happening on the photographs, their reasons for taking the photographs, the significance of the photographs and lessons learnt from the photographs.
    - Photographs can also be reflected upon in writing, prompted by open-ended questions
    - Participants identify key themes emerging from their photographs and reflections.

7. **Dissemination**

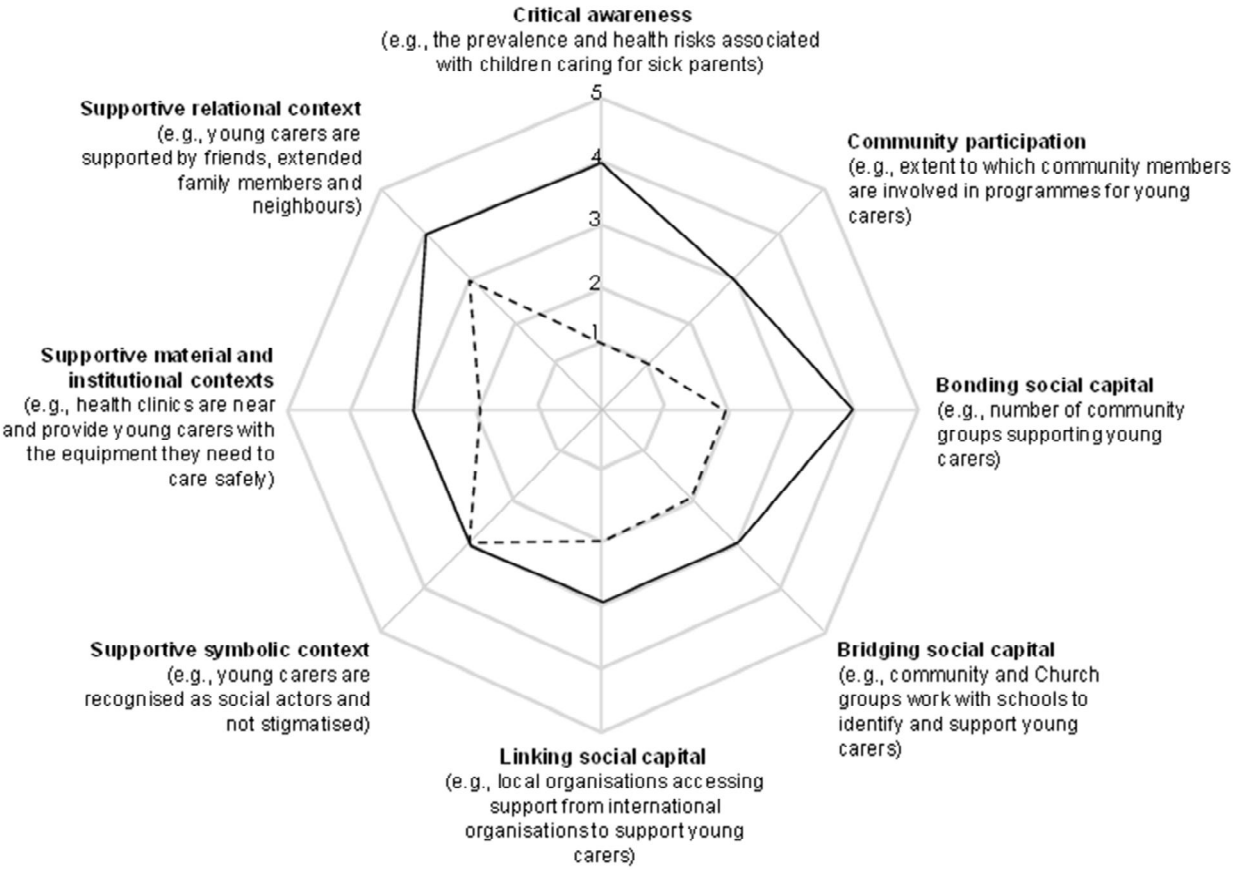
Facilitate the creation of posters/power point presentations depicting key take away messages using the photographs and voices of the participants and exhibit them in a public space.

Example 2: Spidergrams

A Spidergram is a web-like diagram that has lines on which community health competence, or community participation, can be evaluated by community members themselves (Rifkin and Pridmore 2001; Draper, Hewitt et al. 2010). Community members can come together to discuss a health issue and decide to assess their competence, or preparedness, in this area, giving themselves marks on a scale from 1 (poor) to 5 (excellent) on various categories. Spidergrams can be drawn up prior to a health promotion programme, giving community members a chance to reflect on what changes need to be made, and at the end of the programme to see if the community's level of health competence has changed during the course of the programme. This exercise can give community members an insight to some of their strengths and weaknesses in working towards a more health-enabling social environment as well as clarify their role in the response towards improved health.
Figure 6.3 illustrates an example of a Spidergram which shows a community assessing their competence in relation to children caring for sick parents. The example shows a dotted (time 1) and a solid (time 2) spider web, depicting change in community health

competence from one moment in time to another (e.g., before and after a health promotion initiative). The Spidergram in this example incorporates eight key areas important to community-level health promotion, reflecting the material presented in this chapter. However the Spidergram could have fewer arms and be used to assess participation in areas such as leadership, organisation, resource mobilisation, management and needs assessment.

Figure 6.3: Community health competence Spidergram



Adapted from Draper, Hewitt et al. 2010

Activity 6.4

Activity: In this activity you will consider the practical issues involved in engaging communities by simulating using Photovoice to plan a health promotion intervention. Think of a local context familiar to you and a health issue that this community is battling with. You would like to make the wider community more critically aware of this health issue as well ensure that the local health department

is aware of the information you will gather in the process. You decide to use Photovoice. Develop a plan detailing your implementation steps

Feedback:
There are a number of questions you might consider in developing your plan. These include:

- What are your broader goals and objectives
- Where will funding come from?
- What community leaders should be involved?
- Who are you targeting? Policy makers? Community leaders?
- How many will be involved in the Photovoice exercise? Will they be working individually or in groups?
- What is their involvement in the planning of your Photovoice project
- How (content) will you train them on the methodology? Use of cameras? Ethics?
- What informed consent measures must be in place?
- What is guiding their photography? Think of questions they can answer through photography
- How long will the project last? How many photos/rolls of film do you expect them to take?
- How often do you meet to discuss photographs?
- In what fora will you be discussing the pictures? Group discussions? In writing?
- How do you intend to reach the target audience?
- How will the findings be disseminated?

Remember, Photovoice is flexible and there is no set guideline on how to implement a Photovoice project. Use your creativity and local knowledge to develop a project that has the greatest chance of instigating change for improved health.

Skills and attitudes of health promoters at a community level

Health promotion at a community level is not apolitical and should not be reduced to tasks, tools and technical solutions. Health promoters work within wider societal structures that are characterised by power, resources and dominant health technologies. Community health promoters are therefore often given the very difficult task of serving as intermediaries between health professionals and people at a community level, bridging global health technologies and local responses to improved health. The values of health promoters and how they approach their role and work with communities therefore matter

tremendously. Developing partnerships that transcend power hierarchies, conflicting values and knowledge systems, and successfully work together to promote the health and well-being of marginalised people, require good interpersonal and cross-cultural communication skills. It is very easy for community health promoters to succumb to the production of expert and technical solutions, particularly if a genuine and deep seated commitment to community development, empowerment, social justice principles and the need for community-defined problems and solutions is absent. Community health promotion is arguably not for everyone. It is the role of the health promoter to recognise his or her commitment to community work and to

- be reflective of power hierarchies and structures, both within communities and between local and global actors.
- recognise, respect and be committed to the principles of community participation and social justice.
- be a good facilitator, develop skills to be a good listener, be positive, respectful and open to new ideas.

Summary

In this chapter you have learnt how theories can help you conceive and plan health promotion programmes at a community level. More specifically, you have learnt about the role of critical awareness, participation and social capital in creating health-enabling social environments that empower people to take control over their own health, and the health of others. The chapter has also highlighted that health promotion practice at the community level needs to be nested within a context, spanning from the wider social influences that enable and limit community level health responses to the values and interpersonal skills of health promoters. Only by taking this holistic view will we be able to create the necessary conditions for health through community empowerment and participation.

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Tools together now: 100 participatory tools to mobilise communities for HIV/AIDS, available on the worldwide web from the International HIV/AIDS alliance.