Lecture Notes on Community Change in Public Health

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Contents

1 Week one

1.1 The Ecological Model: five levels of change

The **Ecological Model** provides a framework for identifying reasons for public health problems as well as for planning interventions. The basis of the model is the recognition, that public health problems are rarely caused only by wrong individual behaviour but rather by a combination of factors from five different levels:

(1) Intrapersonal factors - individual level: What do individual people know about public health problems? What do they think about proposed solutions? What benefits and problems do they see?

(2) Interpersonal factors - social network level: Who makes family or household decisions? How much money is availably in households and families and how are spending decisions reached?

(3) Institutional factors - organizational level: Who has real influence in the community? Are there organizations that prevent positive changes or that could help bring about those changes? How do the local marketing and distribution systems work?

(4) Community factors - community level: Is there any institutional support for solutions to public health problems? Have public health problems even been identified as problems for the community by the formal and informal leadership? What roles are played by local businesses, schools, clinics, NGOs and other associations?

(5) Policy factors - national level: What influence do national policies (e.g. laws, tariffs, grants, taxes) have on the public health? Which parties and interests are involved in the policy-making process?

The Ecological Model is not just used to identify problems but also to identify key people, groups and resources that can help bring about positive changes.

1.2 What is a community?

Different kinds of communities can exist even within the boundaries of one city. But what exactly is a community? Most definitions of this construct include the following attributes:

- same location (not always, e.g. online communities)
- same basic values and social norms
- same interests (e.g. economic or political)
- a shared sense of belonging and identity

To identify, analyse and 'cure' health problems within a community, the community must first be 'diagnosed'. Just as a physician has to diagnose various systems within a patient (e.g. respiratory system), we need to look at **five different systems within a community** to come to a diagnosis:

(1) Social system: Defines basic units (e.g. family) and their roles in the community

(2) Political system: Defines power relations between groups and leadership roles

(3) Cultural system: Defines the basic beliefs, values and norms of the community

(4) Economic system: Defines how resources are distributed and incomes are generated

(5) Geographic system: Defines where resources are located and how available space is used

Community maps and Geographic Information Systems (GIS) today play an important role in community diagnosis. They can help to identify different social groups, find out who has access to which resources and what infrastructure is available. It is preferable to include the communities in the process of map-making to find out how people within the community see things.

Four important characteristics of communities are:

(1) Identity: Identity is defined as a sense of belonging and sharing a common destiny as well as a common set of values and norms. In a community with a strong identity, people tend to trust each other, get along well and are able to work towards common goals.

(2) Integration: A high level of integration is reached through interaction within a community. Such interaction can be observed on self-organized markets or at cultural festivals.

(3) Group orientation: In a community with high group orientation, the needs of the group take preference to the needs of single individuals. A sign for a high group orientation can be a strict system of social control.

(4) Linkages: Linkages are defined as the connections of the community to the outside world through individual or institutional channels. A community which is represented in the national government by representatives out of their own midst is, for example, a well-linked community. Thus, the linkage of the community defines whether they are more or less cut off from the outside world or whether they have the ability to communicate their needs to journalists and politicians.

By analysing these basic characteristics, we can identify **six basic community types**:

(1) Integral community: An integral community has a strong sense of identity and a high level of integration while also being highly linked to the outside world.

(2) Parochial community: A parochial community has a strong sense of identity and a high level of integration. Links to the outside world are, however, minimal, thus the community is cut off.

(3) Diffuse community: A diffuse community is characterised through a strong sense of identity and belonging as well as a low level of integration. In these communities, which often consist of a strong and homogeneous middle class, outside linkage takes preference to inside integration. As a result, diffuse communities exhibit a low intensity of community life and activities.

(4) Stepping-stone community: Most members of a stepping-stone community are looking to move forward to other communities with a higher socio-economic status. Thus, the identification with the current community is rather weak while outside linkage is high.

(5) Transitory community: A transitory community is a community where a population change is currently under way. Due to the changes within the community, there is usually little community organization and integration. If changes occur too fast, the community might break up into newcomers and people who have been living in the community for a longer period of time.

(6) Anomic community: An anomic community is pretty much a failed community. It is weak on all points: identity, integration, group orientation and linkage. Anomic communities are usually not able to mobilize strength for common action without outside intervention.

1.3 Offensive, defensive and hidden communities

The last lecture of week one presented an alternative community typology:

(1) Offensive community: An offensive community is a socially healthy and vibrant community that is highly visible through community activities, festivals etc. It usually has an active middle class with both the time and the resources for community organizing. If changes are to be initiated in such communities, the local leadership has to be included and given the opportunity to take charge.

(2) Defensive community: A defensive community is more reactive than proactive, meaning that it reacts to certain problems but does otherwise not actively seek to improve itself. If changes are to be initiated in such communities, solutions have to come from outside.

(3) Hidden community: A hidden community is a community so poor, that poverty overshadows all other problems and that the daily fight for survival makes any form of community organization almost impossible. As a result, the community is barely visible as a community. If changes are to be initiated in such communities, interventions usually work best on a case-to-case or a household-to-household basis, since there is hardly any internal leadership that could support positive changes. It is very difficult to reach hidden communities or to initiate positive changes within them.

2 Week two

2.1 Community efficacy and competency

In community management, we differentiate between the two concepts of **community efficacy** and **community competency**. Community efficacy describes the self-perception of communities by their members: Do the people in a community believe that their community is capable of mobilizing the strength and the resources to bring about positive changes? Community competency, on the other hand, describes the actual capability of communities to do these things.

The **three major components of community efficacy** are:

(1) Social control (self-enforcement of norms)
(2) Cohesion (integration and interaction)
(3) Identity (sense of belonging)

Community efficacy is actually measureable by questioning community members about their perception of the capabilities of their respective communities. Studies indicate, that a high community efficacy strongly correlates with actual community competency.

A **competent community** can:

- identify problems and needs
- set goals and priorities
- agree on ways to implement changes
- collaborate effectively to bring about changes

It is important to note, that community competency and the empowerment of the individual are strongly linked: If the community in general feels competent (meaning that community efficacy is high), its individual members are more likely to feel competent as well. Therefore, changes in a community and changes in individual behavior are closely interwoven.

2.2 Rothman's model of community change

The lecture on community change models contained a comparison between the so-called functional view on community change and the so-called conflict view on community change:

Functional view: Communities change, when parts of their systems break down or massive external changes ocurr. These events force changes in social norms and thus changes in the community.

Conflict view: Change in communities is driven by the struggle for power between different interest groups. If new interest groups form or interest groups, who are not currently holding much power, do manage to ascend, they (re)form social norms which, in turn, leads to community change.

The rest of this lecture centered on **Rothman's model of community change**. It differentiates between four ways, in which community changes can take place: Change can either be initiated from the outside (social policy planning, community mobilization) or from within the community (community action, community development) with the necessary resources coming either from the outside (social policy planning, community action) or, again, from within the community (community development, community mobilization).

(1) Social policy planning (outside initiation, outside resources)
(2) Community action (inside initiation, outside resources)
(3) Community development (inside initiation, inside resources)
(4) Community mobilization (outside initiation, inside resources)

Social policy planning

- Outside experts design and implement models for communities
- The implementation is also forced from outside (laws, taxes)
- Social policy planning often is a reaction to specific problems

Community action

- Members of a community identify power imbalances / missing resources
- Members organize themselves to get access to these outside resources
- Media help is important in getting the message to decision makers
- Any form of community action needs one or more strong leaders

Community development

- Members of a community self-mobilize internal resources to initiate changes
- This change process is completely under the control of the community
- New solutions are often built on indigenous knowledge and traditions

Community mobilization

- Outside experts design solutions but do not implement them from the outside
- Community members are expected to contribute via donations and work
- People are often encouraged to join the effort via social marketing

3 Week three

3.1 The Political Economy Framework

Just like the Ecological Model from the first week of this course, the **Political Economy Framework** is yet another theoretical model for explaining community change processes. It is somewhat similar to the Ecological Model in that it is comprised of (three) layers, starting with the individual person (the intrapersonal layer in the Ecological Model) and ending at the level of national and even international government (the policy layer in the Ecological Model). The Political Economy Framework is comprised of the following three layers:

(1) Individual layer: Individual people and families

(2) Organizational layer: Local and supralocal organizations

(3) Political economy layer: National and international policy level

The model recognizes that communities can be comprised of higher and lower classes with very different access to power and resources. Such classes can be defined, for instance, by gender, wealth, ethnicity, land ownership, religion, family heritage or occupation.

The model differentiates between three types of power as well:

(1) Situational power: The ability of individual persons to make their own decisions (e.g. regarding healthcare) within the given framework of political power (individual layer).

(2) Organizational power: The ability of local and supralocal organizations to influence the existing power framework in order to achieve their goals (organizational layer).

(3) Systemic / structural power: People who are holding actual structural power are able to shape the political framework and thus define how the game is played (political layer).

3.2 Community participation

Community participation in health projects increases community efficacy and usually leads to not only a better use of local resources but also to a higher acceptance of health measures by the local community members. Participation is - in this context - defined as the active involvement of community members in decision making processes as well as in the implementation of solutions. Higher levels of participation benefit the health of the community in various ways: people are more involved in spreading and implementing health solutions, local resources are put to better use, local needs are considered more aptly (no 'one size fits all' solutions) and decisions are generally better accepted.

It is important to note, that even good ideas and valuable programs might not be accepted by a community if they are seen by people as being forced upon the community from outside NGOs or government officials. The better strategy often is to educate community health workers and then turn most of the outreach, implementation and evaluation over to them. This principle has been proven true in many primary health projects over more than three decades, ranging from water filtering (for preventing guinea worm desease) to well construction, child inoculation and use of contraception. An effective community health program can, however, still start out as a typical social policy planing effort (being initiated from the outside) and then be slowly turned over to more and more local control.

3.3 Levels of community involvement

Prof. Brieger differentiates between **five levels of community involvement** in (health) programs:

(1) Acceptance: Acceptance merely means passive cooperation, such as the use of health services provided by an outside agency. This level of involvement includes no active participation on the side of community members (e.g. putting up a mosquito net offered for free by an NGO).

(2) Mobilization: At the mobilization stage, the program is still run from the outside, but valuable input and ideas are provided by community members (e.g. obstacles with mosquito net use are actively discussed with the outside agency).

(3) Participation: Participation implies, that community members carry out parts of the program themselves and voluntarily contribute to it (e.g. community members with authority make the public case for mosquito net usage and see that nets are distributed within the community).

(4) Involvement/planing: At this stage, the program is not longer run completely from the outside. Community members plan and evaluate measures themselves, the community is given a high level of autonomy (e.g. a community health center is up that actively promotes distributes mosquito nets and has people regularly going from door to door to see if the nets are actually being used).

(5) Control/ownership: At this stage, the program is not longer run from the outside but is in total control of the community. Community members decide not only on the goals, which they are trying to reach, but also on the methods by which these goals should be accomplished. Outside agencies at this point only provided needed resources and outside contacts (e.g. a mosquito net program that is completely run within the community, whith local businesses buying and selling the nets with some help by outside agencies and local health centers advocating and controlling net usage).

When success and failure of a program are not seen as the success and failure of the outside NGO or agency by the community, but as success and failure of the community itself, an optimal level of involvement has been reached. Reaching that goal requires outside agencies to give up control over the program and accept local decisions, even if they are based on beliefs and customs that might not be shared by the respective agency.

4 Week four

4.1 Community coalitions

While the lectures of the third week were all about different power imbalances within the Political Economy Framework, the fourth week centered around the dynamics of community coalitions, that form out of the need to correct such imbalances. Community coalitions can - for example - be focused on public health issues - such as the so-called Community Partnerships for Health (CPH).

A **community coalition** is basically a group of people who are combining their skills and resources to achieve a particular, clearly defined goal. As coalitions grow, they increase their visibility within as well as outside their respective communities and may reach a critical mass, attracting more and more supporters as well as help and attention from the outside.

There are **three basic types of community coalitions**:

(1) Grassroots coalitions: Grassroots coalitions usually form as (political) pressure groups that attempt to address or adjust a specific problem. They are usually just short-term formations.

(2) Professional coalitions: A professional coalition is a volunteer organization of professionals (e.g. physicians, nurses, engineers) that combine their know-how and influence. Professional coalitions are usually meant to last long-term.

(3) Community-based coalitions: In a community-based coalition, elements of grassroots and professional coalitions are combined in order to form an effective, long-term alliance.

Whether a coalition is successful, depends on a number of factors:

- Successful communities need to have a clear set of realistic, reachable goals (motivation)
- Successful communities depend on a clearly communicated set of rules and good leadership
- Newly founded communities need some quick (low-level) successes which hold them together

- Diversity makes communities effective - e.g. bringing together people with different resources, influence, skills, inside and outside contacts etc. for a combined effort

4.2 Case study: Onchocerciasis treatment

Two of the three lectures of the fourth week reflected on various attempts to combat **Onchocerciasis** - the so-called **river blindness** (see explanations below). This parasitic disease can be treated with the drug Ivermectin, which has to be applied long-term (for about 15 years) to be effective. This means, that any really successful treatment programme has to be sustained for 15 years (with one dose of the drug given per year and person) even in remote villages in sub-Saharan Africa. Against the background of this problem, Prof. Brieger examined the differences between a community-based and a community-directed treatment programme.

Community-based programmes: A community-based health programme follows the social policy planning approach discussed during the second week of this course. An outside NGO (such as the APOC - the African Programme for Onchocerciasis Control) basically plans the intervention from the outside and then comes into the community to carry it out. The members of the community are therefore simply recipients of an outside service, but have no 'ownership' of the programme. This reduces the commitment to and the interest in the programme and therefore its effectiveness. It is also noteworthy, that outside health workers are usually under some pressure to present positive statistics to their superiors and are thus inclined to 'push' measures on community members.

Community-directed programmes: A community-directed programme is initiated from outside the community by a NGO or government organization, but is then - sooner or later - gradually passed over to the community itself. Such community ownership means e.g. that the members of the respective community can decide among themselves, which community members shall receive health worker training by the NGO, who shall be responsible for the distribution of the drugs and when and how the drugs shall be passed out to the community members. The outside agency is simply acting as a facilitator to this process, providing the drugs itself as well as advice and outside resources needed for a successful project. Such **community ownership** practically guarantees that local issues and sensitivities are respected and that the programme is better accepted. Additionally, running a community-directed programme builds up skills and organizational structures within the community, that can prove to be very useful for future health- and non-health-related projects.

About Onchocerciasis / river blindness

The lectures of the fourth week centered around efforts to combat Oncochericiasis in sub-Saharan Africa. Oncochericiasis - or river blindness - is a severe parasitic disease caused by a roundworm (*Onchocerca volvulus*). This specific parasites spreads to hu-

mans via the bite of the black fly and can cause severe infection in the eyes, leading - at least in some cases - to permanent blindness. The WHO estimates that about 18 million people worldwide are currently suffering from river blindness - with about 270.000 cases of actual permanent blindness caused by the disease:

http://www.who.int/water_sanitation_health/diseases/oncho/en/

5 Week five

5.1 Community directed interventions

A **community directed intervention** takes place, when the community takes an active part in distributing health commodities. NGOs or government agencies only have a facilitating role (e.g. supplying medicine and other health commodities as well as providing health education and other forms of outside support). A successful example for a CDI approach is the Onchocerciasis control program which was introduced in lecture week four. Further research into the efficiency of the CDI approach has revealed, that this approach can be successfuly applied in other areas (even outside of the health realm) as well (e.g. water sanitation, immunization, bednet distribution etc.)