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Community-Based Participatory Health Research: Promoting Health Equity In Communities

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Abstract

This article is based on a PhD-project, which deals with the issue of health (in)-equity in South Tyrol, Italy. The research project was developed and supported during my PhD-study in Social Work and the participation in the certification course in Participatory Health Research from the International Collaboration of Participatory Health Research (ICPHR). The project runs from 2014 to 2016 and is now in the phase of data-collection, so this is a work-in-progress paper. After giving a short overview about some theoretical background this article focuses on explaining how Community-Based Participatory Research (CBPR) can promote health equity.

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1. Introduction

“Poor die earlier”, say health reports. But “Health for All in the 21st century”, says Agenda 21 from WHO (World Health Organisation). So why is there still observable this gap in health and how can it be reduced? One of the primary goals of actual WHO's strategies is to reduce health inequalities and to promote health equity. Infectious diseases are no longer the acute dominant health hazard in European countries, but living conditions and lifestyles of communities and societies are. Not all people have equal possibilities to be healthy; social differences create unequal opportunities for being and feeling healthy. At the same time, social differences have an enormous impact on people's health (Marmot & Wilkinson, 2003; Naidoo & Wills, 2009, WHO, 2011).

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Health is not only “...a state of complete physical, mental, and social well-being” (World Health Organization [WHO], 1946) but also “(...) a resource for everyday life, not the objective of living (...)” and “(...) a positive concept emphasizing social and personal resources, as well as physical capacities” (WHO, 1986). For promoting health and reducing health inequalities, therefore, it is not enough to focus on disease or infirmity, but it is necessary to focus on health assets which are any factors, “that enhance the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain and sustain health and well-being and to help to reduce health inequities (Morgan & Ziglio, 2007, p. 18)”. Building on the model of social determinants from Dahlgreen & Whitehead (1991) health is seen as a holistic concept and so health equity is not only equity in using Health Promotion structures and services, but equity in opportunities, in capabilities, in ‘commons’, etc. Communities often have the assets and skills to overcome health challenges, however they are often not aware of these assets, how to access them and how to use them to address health challenges. Therefore this research project – after giving an overview about the situation of health equity in South Tyrol as a whole region – is working on mobilizing local health assets for health equity in one community. The overall aim of the research project is to give an overview of the state of arts in international research on Health Promotion and health equity, to identify existing health inequalities in the research region and to show how Community-Based Health Promotion can give an important contribute to promote health equity (in rural areas). This paper focuses on the third part of the research project.

1. Theoretical background – Health, Health Promotion and Health Equity

1.1. Health as a positive concept

The general term *health* can be defined in very different ways; different societies and cultures have different ideas of health. In everyday life health is often interpreted negatively, health is seen as the absence of disease without a positive description. This medical understanding of health is deeply rooted in most industrialized countries; health is not defined by what it is, but by what it is not. A positive understanding of health believes that health is a state of well-being. The sociological perspective is a powerful antidote to the scientific medicine, by pointing to the importance of social factors (Naidoo & Wills, 2009). Through the definition of health as “a state of complete physical, mental and social well-being” (WHO, 1946), the WHO has laid the foundation for the development of the bio-psycho-social model of health. This holistic view of health is not a static condition, but a constantly moving process. Whether health is considered in a positive or negative way is especially significant.

1.2. Health (in)equity – the connection between social and inequities

Despite the general increase in life expectancy not all citizens have the same opportunities for being and feeling healthy and for living a healthy life. The sociological term social inequality explains that unequal distribution of valuable resources lead to positively or negatively privileged living conditions (Franzkowiak, Homfeldt & Muhlum, 2011). Social inequalities in health status narrow differences in the conditions and behavior that are socially determined in a broader sense (Leon, Walt, & Gilson 2001). International research has achieved significant advances in knowledge in the explanation and description of the relationship of social and health inequalities in recent years. In all countries where data are available a serious trend to socially unequal distribution could be detected. (Hurrelmann & Richter, 2006). In modern European welfare states it is not about absolute defects or insufficient supply of the necessities of life, but the unequal distribution of resources between different population groups. This social inequality is a fundamental structural feature of modern societies (Klemperer, 2010). If we assume that this inequality is avoidable, then we must seek to mitigate and eliminate these inequalities. Therefore research on social and health inequalities should be of great importance for Social and Health Sciences.

1.3. Health Promotion as a salutogenetic concept

Health Promotion is a sub-discipline of Public Health, which is a collective term for various disciplines. As opposed to individualized medicine Public Health concerns the population aspects of health, including Health Promotion and disease prevention in regions and institutions (Siegrist, 2005). Not the treatment of diseases, but the causes and conditions of health and disease are the focus of Public Health research. While *Old Public Health* is

geared to individuals, to risk factors and health education, *New Public Health* focuses on the social determinants of health (Klemperer, 2010). Prevention strategies aim to change the people's behaviour and attitudes to minimize risk factors, while Health Promotion works resource-oriented and wants to change behaviour and conditions for promoting health. Due to the dominance of bio-medical model Health Promotion is often mistakenly understood as disease prevention (Naidoo & Wills, 2009). Health Promotion includes a range of very different activities, therefore there does not exist a clear definition of the term Health Promotion, but a description of the activities. Health Promotion includes all measures that are designed to promote health and to manage disease. A number of international WHO-conferences with their declarations were finally the basis in defining and developing new approaches to Health Promotion, especially the Ottawa - Charter from 1986. There in the WHO has formulated a concept for positive and comprehensive Health Promotion, which builds on social science theories. "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members" (WHO, 1986). So the Ottawa - Charter connects Health Promotion with social sciences: "Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. (...) Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (...) The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity" (WHO, 1986). Health Promotion is about a change of life options which promote health. For working in this field of tension of behaviour and conditions it is necessary to take different approaches, concepts of social sciences must work together with health sciences. The development and implementation of Health Promotion for socially disadvantaged groups for various reasons is a special challenge.

1.4. Community-Based Health Promotion to promote health equity

The setting-approach from Social Work can be considered particularly suitable for Health Promotion. Socially disadvantaged people and groups should be reached in their everyday lives. The historical roots of community work go back to the English settlement movement in the middle of the 19th century and their American variants (Galuske, 2009). The settlement movement is based on *Toynbee Hall*, founded by the Rev. SA Barnett. Together with his family and students Barnett has worked on improving the living conditions of people living in a slum population of London. Jane Addams founded together with other American women Chicago's Hull House. (Muller, 2009). The Brazilian educator Paulo Freire worked during the 1970s on education programs for impoverished farmers in Peru and Brazil and influenced the approach of community work significantly. Murray Ross defined community work in 1955 as a process during which a community defines its needs and goals, arranges them and brings them in a hierarchy, develops confidence and the will to advocate for these needs and objectives, mobilises internal and external sources, implements measures and develops an attitude and practice of cooperation and collaboration in the community (Ross, 1955). Community work means resource orientation and activation of self-help potential in one's own living conditions (Hinte & Karas, 1989). While community work seemed almost forgotten for quite a long time in many European countries now there is observable a comeback. Community Work with explicit health objectives is called Community-Based Health Promotion (CBHP). CBHP is a strategy to empower people in order to determine the factors which influence their health (Naidoo & Wills, 2009) and it seems to be especially effective for promoting health equity. As "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986), Community-Based Health Promotion seems to be a good strategy to involve all people in Health Promotion projects.

2. Promoting Health Equity through Community-Based Health Promotion: a participatory research project

2.1. Research Approach

This paper is based on a participatory social and health research project conducted in South Tyrol (Italy). Participatory Research is seen as a research approach, and not – as often used to be – a research method. Participatory Research for Health Equity is mainly driven by the International Collaboration for Participatory Health Research (ICPHR) and the North American Community-Based Participatory Research approach (CBPR). Participatory Health Research and Community-Based Participatory Research can be described as a further development of Action Research, which has the goal to make research useful for emancipatory and democratic promotional purposes in order to find practical solutions. Levin says that “research that produces nothing but books will not suffice” (Lewin, 1946, p. 35). As Action Research has the purpose to produce practical knowledge that is useful to people in the everyday live and which should increase the well-being of human persons and communities, works towards practical outcomes and creates new forms of understanding and leads not just to new practical knowledge, but to new abilities to create knowledge (Reason & Bradbury, 2001). Community-Based Participatory Research can be defined as community oriented Participatory Health Research. It is characterized by the involvement of practitioners and community members as experts in research (Israel et. al., 2003). The involvement and participation of community members has to be assured in all phases of the research. Especially social and health disadvantaged communities benefit from the collaboration, as from a public health perspective, action is required to promote individual and collective self-determination, empowerment, to develop skills (capacity building) and to improve their health prospects (Minkler and Wallenstein, 2003; ICPHR, 2013). Community-Based Participatory Research aims to obtain new findings about the health resources and risks and to develop action strategies for Health Promotion and Prevention. Methodologically Community-Based Participatory Research and Participatory Health Research can be defined as strategies or approaches, which can make use of qualitative and quantitative methods. In the ICPHR Strategy Paper this is described as follows: "Participatory Health Research is a research paradigm rather than a research method" (ICPHR, 2013). Wright, Von Unger and Gardner (2010) indicate that further work is needed, especially to a determination of quality in Community-Based Participatory Research. Because of the diverse influences on health and the difficulty to health, it hardly seems possible to detect empirically the extent to which health equity can be promoted through CBPR. Especially social and health disadvantaged communities benefit from the collaboration, as from a public health perspective, action is required to promote individual and collective self-determination, empowerment, to develop skills (capacity building) and to improve their health prospects (Minkler and Wallenstein, 2003; ICPHR, 2013). To promote research in terms of promoting health equity a further discussion of this approach appears important for future European Social and Health Research.

2.2. Research Setting

South Tyrol is an autonomous province in northern Italy; it is a borderland to Austria and Switzerland. The majority of the population speaks German as their mother language, around a quarter of the population speaks Italian, mainly concentrated to the two largest cities, and another minority speaks Ladin. South Tyrol is highly mountainous, it a very rural areas without big cities. While other European countries and regions have been increasingly devoting the issue of health equity for years, there is no research about health (in)equity in South Tyrol yet. For the community-based-research-project the participatory project was implemented in one South Tyrolean Village. It is a village with about 4.000 inhabitants, a typical rural area with mostly German speaking population. The research project was developed in intensive collaboration with volunteer-associations and several community members. Trough creative innovative participative methods it is possible to involve practitioners and community members in every part of the research project, what is one of the basic principles of CBPR and PHR (Israel et. al., 2003). The research community was already interested in the topic of Health Promotion before the research idea started; there have already been several small projects on life quality and Health Promotion, especially promoted by local policy makers and some volunteer associations. It is a community with several special health resources (like a small lake, trekking paths, ...) and health risks (like the main North-South Motorway, Highway, and Railway, which goes through the middle of the village). After several meetings with associations and policy makers was decided, that there should be elaborated strategies for Health Promotion in the community with a special focus on not forgetting socially disadvantaged groups, but by organizing the project with the most possible accessibility. The research process of this project has emancipatory and democratic promotional purposes in order to find practical solutions for health risks and to enable people to use health assets for health equity.

2.3. Research Questions

While citizens see the implementation of Health Promotion Offers as the primary goal of the project, the researcher has the goal to implement a participatory research project. It is a common key-interest to analyze health resources, assets, risks and needs in the community. Building on this there should be developed and implemented several Health Promotion programs. Another key-question from the researcher s to analyze, how Community-Based Health Promotion can involve socially disadvantaged groups in the whole process and if Community-Based Health Promotion can promote health equity.

3. Conclusion

First outcomes indicate that there is still missing data about health inequity in rural areas and especially about how to promote health equity. Literature analyses, the discussions with experts and first outcomes from the Community-Based Participatory Health Research project show that Community-Based Health Promotion can be a powerful way for promoting health equity in communities. One interesting key-element of the participatory project is that not only the outcome of the research project should bring some important data for eventual chances and improvements, but already the process of research promotes social change and can be defined as Health Promotion process for the community. This project should provide an important contribution for the future planning of Community-Based Health Promotion projects for health equity and for the further development of Participatory Social and Health Research.

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