

Health as a Social Movement: Developing an overarching theory of change

Introduction

A theory of change is a way of thinking about how a programme will lead to outcomes and goals. Theories of change describe the changes you want to make, the steps involved in making those changes and how these relate to each other.

This paper outlines a theory of change developed for NHS England's Health as a Social Movement (HAASM) programme. It sets out an overarching theory of change which identifies the high level outcomes and goals common to the six HAASM sites. This has been created for three main reasons:

- *Shared understanding.* The process of creating the theory of change aimed to enable partners to come to a shared understanding of the programme, and think about how the different pieces of work support each other.
- *Measurement.* The theory of change will set out a series of outcomes, so that progress towards achieving them can be measured during the evaluation stage. The evidence generated will enable us to demonstrate to others within the NHS and beyond of the validity of this approach.
- *Communication.* A theory of change is a clear way to summarise and communicate the aims and goals of a complex programme.

The theory of change has been developed in a three stage process: (1) collating and analysing the available literature, knowledge and insight into community based health programmes; (2) group discussions with local partners about initial plans, understanding of the programme and outcomes they hope to achieve; (3) a workshop bringing together local partners to think about social movement characteristics and programme outcomes, and to discuss a draft theory of change.

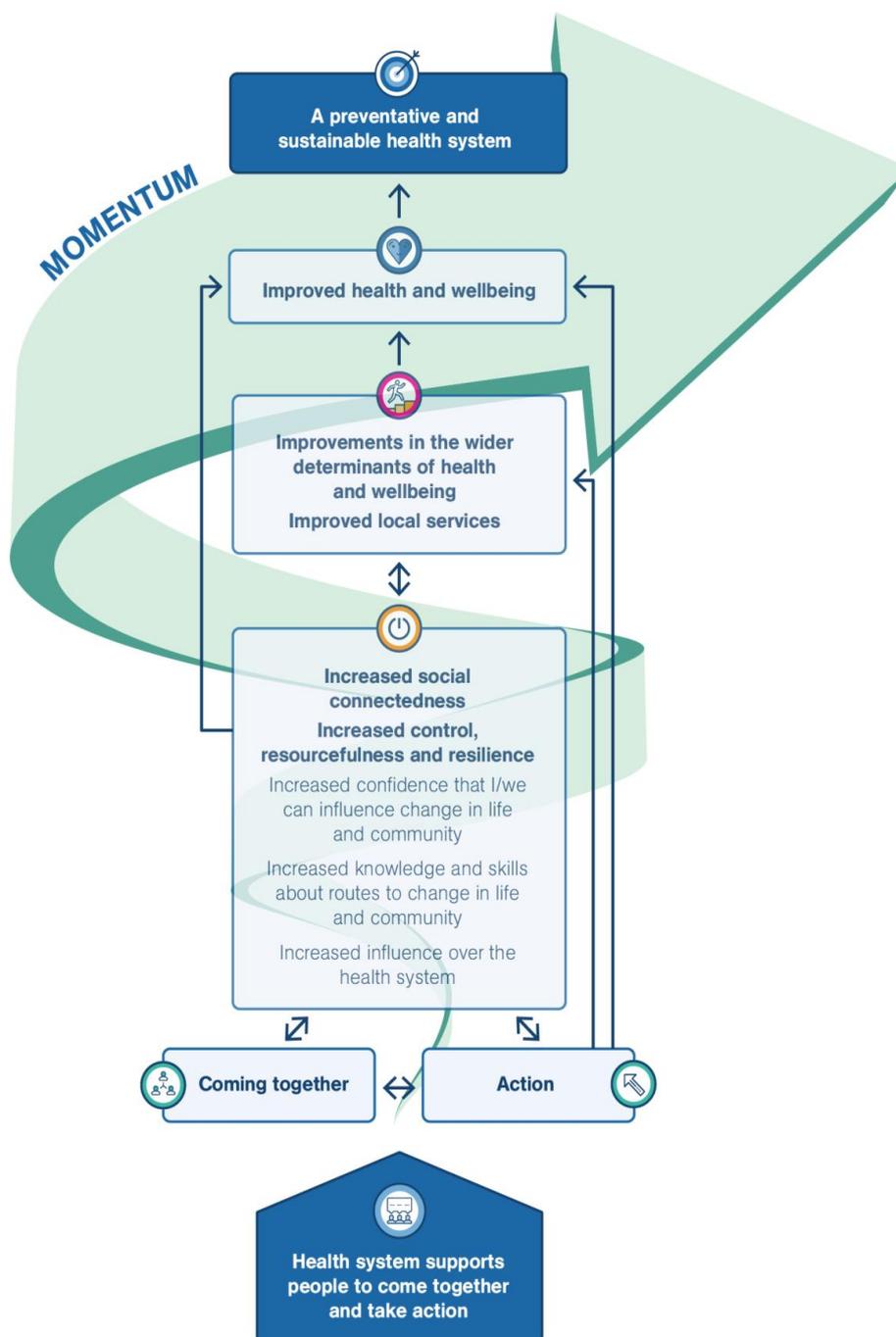
The resulting theory of change diagram is outlined below, followed by a description of the diagram in words and an outline of the available evidence supporting the theory. It is important to note that many of the outcomes in the theory of change are ambitious and the Health as a Social Movement programme can only contribute towards these. There are many other influences on outcomes such as 'a preventative and sustainable health system', 'health and wellbeing' and 'improvements in the wider determinants of health'. Additional influences upon these

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outcomes include other programmes initiated by NHS England as part of the New Care Models programme, wider statutory and voluntary sector initiatives operating in the area as well as the wider social, economic and environmental context.

The further you move up the theory of change diagram, the less the Health as a Social Movement programme can be responsible for the outcomes presented.

An overarching theory of change



Theory of change in words

*Box A: Community gardens in Localtown**

Bernie, a middle-aged man from Localtown, had been feeling lonely and this was really getting him down. One day Bernie bumped into an old friend, Mac. Mac was starting to clear an allotment to grow fruit and vegetables, and so Bernie went along to help out.

A few months later, Bernie had a health check-up with his GP. When he mentioned the allotment, his GP asked if they needed any extra help. The GP put an advert up in the surgery and included information in the monthly patient newsletter. Ten people got in touch and started meeting regularly at the allotment to garden together.

When walking home one night, Bernie noticed an overgrown patch of land that was being used to dump rubbish. With permission, and a little bit of money, the disused patch of land could be used as an additional allotment.

The experience of setting up the allotment with Mac (*coming together* and *taking action*) had left Bernie with a newfound sense that he and his neighbours could make positive change in the community (*increased confidence that we/I can make/influence change in life and community*). As a result, Bernie approached his GP and together they made an application to take on the piece of land (*Increased knowledge and skills about routes to change and increased influence over the health system*). Bernie and a group of neighbours – who had long hoped to see something done with the disused space – cleared the land, and the GP, who regularly met patients whose mental health and wellbeing was affected by their loneliness, started referring patients to the group. More and more people started to get involved (*Momentum*).

Bernie and his neighbours now run a network of thriving community gardens. As well as connecting the community (*social connectedness*) and improving the local built environment, Bernie and his gardening neighbours are starting to sell their produce at discount rates to tackle food poverty locally (*improvements in the wider determinants of health*).

** This is a hypothetical case study used to illustrate a number of the outcomes in the theory of change.*

Health system supports people to come together and take action

The health system (by which we mean the combined institutions of health and health care in the public realm, and how they work together) shifts from 'doing to' to 'working with' people and communities, focusing on their strengths and capabilities in an asset based way.

The exact form of support will vary by local area and will be articulated in more detail within local theories of change.

'Coming together' and 'action'

Local people come together and take action in each of the HAASM sites. Examples of action include:

- Formal volunteering - the use of volunteers through an established framework to enhance and add capacity to public services delivered by public organisations or voluntary and community organisations.
- Informal volunteering and neighbourliness – this type of action can range from doing the shopping for an elderly neighbour, to helping a young person with their homework.
- Time banking – a time-based currency exchange mechanism that incentivises and supports people to contribute unpaid time
- Co-production – a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.
- Peer support – the mutual and reciprocal exchange of emotional and practical support between peers within and beyond public service areas.
- Community organising – an approach to community empowerment and development that focuses on one-to-one relationship-building, community capacity and mobilising people-power to take action.
- Campaigning, activism and direct action – people volunteering their time to make the case for changes or improvements to public services or the wider determinants of health.

The exact form of action will vary by local area as it will be driven by each area's assets and priorities. Each site's activity will be articulated in more detail within local theories of change.

The process of coming together and taking action can directly lead to changes in health and wellbeing, the wider determinants of health and wellbeing and local services, depending on the focus of the action. The process of coming together and taking action can also lead to increased community control and resourcefulness, by increasing confidence, social connectedness, knowledge and skills and influence.

Increased social connectedness

People develop stronger connections within their communities and feel an increased sense of solidarity and trust locally.

Box B: Community engagement, social connectedness and health

Community engagement has been shown to be successful at increasing social connectedness within communities. Milton et al's systematic review of the available literature, for instance, found that:

“Initiatives that aimed to promote community involvement were attributed with gains in social capital, social cohesion and fostering partnership working”.¹

Similarly, a review by Atlee et al found that:

*“the positive effect of community engagement on participants’ social relationships was a recurring theme of the studies in the review’ while ‘experimental evidence also suggests that engagement may benefit a community more widely, in terms of increasing mutual trust and understanding between different population group”*²

Social connectedness has been shown to play a vital role in health and wellbeing, because social relationships have stress buffering effects, can have positive impacts on health behaviours and contribute to a sense of meaning and purpose in life.³

Holt-Lunstad et al, for instance, conducted a meta-analysis of the available data on the subject and found that:

‘Individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The magnitude of this effect is comparable with quitting smoking and it exceeds many well-known risk factors for mortality (e.g., obesity, physical inactivity)’.⁴

Moreover, Cohen and Janicki-Deverts in a similar study state that ‘persons with more types of social relationships live longer and have less cognitive decline with aging, greater resistance to infectious disease, and better prognoses when facing chronic life-threatening illnesses’.

Kawachi et al found that disadvantaged communities that are more cohesive with higher degrees of social capital are more likely to maintain health and are therefore more resilient to the factors pushing less cohesive communities with lower levels of social capital into ill health.⁵

Finally, Marmot Review of health inequalities in England notes that:

*“The links that connect people within communities, often described as social or community capital, can bring a range of benefits. Social capital can provide a source of resilience, a buffer against particular risks of poor health, through social support and connections that help people find work or get through economic and other difficulties.”*⁶

Increased control, resourcefulness and resilience

People and communities are more resourceful and have increased control over their lives and neighbourhoods. Residents and groups have control over decisions that affect them and are agents of change who are ready to shape the course of their own lives and neighbourhoods. Resourceful people and groups are more likely to also be resilient in the face of problems that cannot be prevented.

The mechanisms of change (people coming together and taking action, supported by the health system) can lead to a number of outcomes integral to control, resourcefulness and resilience:

- Confidence – increased confidence that we/I can make or influence change in life and community.
- Knowledge and skills – increased knowledge and skills possible routes to change in life and community.
- Influence – stronger connections between community members and health systems, where communities are involved as equal partners alongside health professionals in creating communities that are healthy and well.

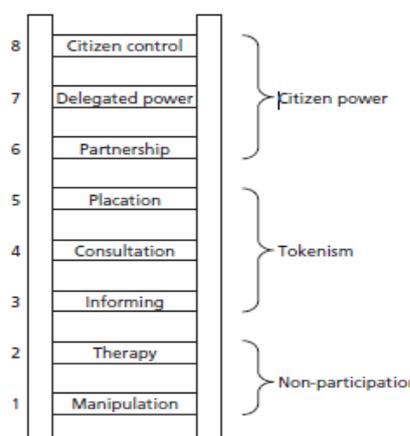
These outcomes are interconnected, with each potentially influencing the others.

Increases in control and resourcefulness make it more likely that communities will take action both inside and outside of the HAASM programme.

Box C: Community engagement, control, resourcefulness and resilience and health

Community engagement is often conceptualised as a sliding scale of control. Sherry Arnstein's ladder is the oldest example of this. Arnstein illustrated the different levels of engagement as an eight level ladder, grouped into three ranks of control: non-participation, tokenism and citizen power. The further you go up the ladder, the more empowerment and control citizens have.⁷

Figure 1:



There is a body of evidence which links community engagement programmes to a sense of control and similar concepts such as self-confidence, self-esteem and self-efficacy. Atlee et al, for instance, note that:

'...active engagement in community initiatives may have valuable psychosocial benefits for participants, in terms of bolstering self-confidence and self-esteem [...] in

addition, some studies suggested that community engagement could have a positive impact on individuals' perceptions of personal empowerment'.

There is a considerable amount of evidence linking individual control and health. Most of the literature on individual control has focused on control in the workplace. Michael Marmot's Whitehall II study, for instance, demonstrates how degrees of control over work decrease with lower ranking positions, and that control predicted a range of illnesses:

'People in jobs characterised by low control had higher rates of sickness absence, of mental illness, of heart disease and pain in the lower back'.

The Whitehall II study has also been used to show levels of control in the home predicts coronary heart disease⁸ as well as depression and anxiety.⁹

There is also a well-established body of literature which posits a strong link between a sense of control (i.e. feelings of powerlessness, helplessness, mastery and self-efficacy) and health.¹⁰ A recent study by Turiano et al found that 'both higher levels of educational attainment and a strong sense of control over one's life independently predict better health and longevity'.¹¹

Although the evidence base around collective control and health is less well established, a body of evidence is beginning to emerge. Piachaud et al, for instance, write that:

"Although less extensive [than the body of research covering individual control] there is also research that suggests that control over resources and decision making at the collective/community level can also have powerful positive impacts on health. Canadian research for example has reported a six fold difference in youth suicide amongst Native American people depending on the degree of community control of key resources including land, health and education services"¹²

Research into community control and health is currently on going in UK. The Communities in Control study, for instance, is currently exploring the relationship between collective control as a determinant of health inequality.¹

Improvements in the wider determinants of health and wellbeing

Improvements in the conditions in which people are 'born, grow, live, work and age'. The wider determinants affected will vary by locality and will depend on the specific

¹ See <http://sphr.nihr.ac.uk/health-inequalities/about-the-communities-in-control-study/> for more details.

actions taken as part of the social movement. The different outcomes sought will be explored in more detail during local theories of change.

Improved local services

Improvements in public services will vary by locality and will depend on the specific actions taken as part of the social movement. This outcome will be explored in more detail during local theory of change workshops.

Community engagement, local services and the wider determinants of health

Within the Marmot Review of health inequalities in England – an evidenced based strategy to tackle the social determinants of health - the concepts of citizen participation and community engagement are acknowledged to be integral to the successful delivery of services aiming to tackle the wider determinants of health, improve health and wellbeing and reduce health inequalities:

“Without citizen participation and community engagement fostered by public service organisations, it will be difficult to provide the penetration of interventions needed to impact on health inequalities [...] promoting this approach sets a new task for political, civic and public service leadership in creating the conditions which enable individuals and communities to take control of their own lives”.¹³

Improved Health and wellbeing

People have improved physical and mental health as well as improved wellbeing. Wellbeing is defined as feeling good and functioning well.¹⁴

A preventative and sustainable health system

Healthier communities with higher levels of wellbeing mean that there will be reduced ill-health and therefore less demand upon the healthcare system. The health system is more effective at preventing ill health, improving the quality of people’s lives and is more financially sustainable as a result.

Growing momentum for change

Programmes are likely to start quite small in scale and grow over time. A programme can be described as a social movement when the mechanisms of change – people coming together to take action, supported by the health system – gather energy and momentum so that change begins to occur at scale. It is likely that the longer the social movement lasts, and the more changes communities see as a result of their actions, the larger the degree or extent of the outcome are likely to be.

Timescales

The outcomes specified in the theory of change have not been assigned timescales. Many of the outcomes in the theory of change could occur quite quickly for the people most involved in the movement. What will take time, however, is for the number of people experiencing the outcomes to grow for the degree or extent of the outcomes to increase and for structural changes in the system to take place.

¹ Milton, B., Attree, p., French, B., Povall, S., Whitehead, M., Popay, J. (2012). 'The impact of community engagement on health and social outcomes: a systematic review'. *Community Development Journal*. Vol. 47, No. 3. p.330.

² Attree, P., French, B., Milton, B., Povall, S., Whitehead, M., Popay, J. (2011). 'The experience of community engagement for individuals: a rapid review of evidence'. *Health and Social Care in the Community*. 19(3), pp.256-257.

³ Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316. doi:10.1371/journal.pmed.1000316

⁴ *Ibid*

⁵ Kawachi I, Kennedy, BP, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. *American Journal of Public Health* 1997;87:1491-1498.

⁶ Marmot, M. G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). Fair society, healthy lives: Strategic review of health inequalities in England post-2010. p.126 Retrieved from: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

⁷ Arnstein, S. (1969). 'A Ladder of Citizen Participation', *Journal of the American Institute of Planners*. Vol. 35, Iss.4.

⁸ Chandola T, Kuper H, Singh-Manoux A, Bartley M, et al (2004) The effect of control at home on CHD events in the Whitehall II study: Gender differences in psychosocial domestic pathways to social inequalities in CHD. *Social Science & Medicine*. 58:1501-9.

⁹ Griffin J, Fuhrer R, Stansfeld S, Marmot M, et al (2002) The importance of low control at work and home on depression and anxiety: do these effects vary by gender and social class? *Social Science & Medicine*. 54:783-98.

¹⁰ See Ross, C. E., & Mirowsky, J. (1989). Explaining the social patterns of depression: Control and problem solving or support and talking. *Journal of Health and Social Behavior*,30, 206–219; and Mirowsky, J., & Ross, C. E. (1989). *Social causes of psychological distress*. New York: Aldine-de Gruyter

¹¹ Turiano, N., Chapman, B., Agrigoroaei, S., Infurna, F. & Lachman, M. (2014) 'Perceived Control Reduces Mortality Risk at Low, Not High, Education Levels'. *Health Psychology Journal*, 33(8): pp.883-890.

¹² Piachaud, D., Bennett, F., Nazroo, J. & Popay, J. (2009) *Social Inclusion and Social mobility: Report of Task Group 9*. Retrieved from <http://www.instituteofhealthequity.org/projects/marmot-review-task-groups>. p.49.

¹³ *Ibid*. p.151.

¹⁴ Aked, J. et al. *Five Ways to Wellbeing*. London: New Economics Foundation. Retrieved from: http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf