OTROS

Protegido: Interview to Antony Morgan

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A social epidemiologist and Professor of Public Health at Glasgow Caledonian University (GCU), he has worked in the health service for the last 30 years, at district, regional and national level. He is a Fellow of the UK Faculty of Public Health. Since January 2016 he has been the Dean of the GCU London campus. He is internationally well known for his work to develop an asset model for health and wellbeing – an approach that tries to create possibilities and life chances for individuals and communities rather than an over reliance on health services to fix problems.

♦ Professor Anthony Morgan, you have played a key role in developing the asset model. How did the conceptualization of the asset model appear?

My first experience of the idea of asset-based working came about when I was invited to work for the World Health Organisation's European Office for Investment in Health and Development in Venice for four months. That was way back in 2004. I had worked in national institutes of public health for over ten years in England and had gained experience of the methods and tools of evidence-based public health within the context of their related social determinants. It took me a while to get my head round the concept of 'assets' but eventually I saw a way in which the principles could be incorporated more centrally into a public health framework to enhance its ability to overcome some of the known difficulties of reducing health inequalities. I used what was already known about asset-based principles (creating health rather than fixing it; appropriate and effective involvement of communities for acquiring health) to produce a framework - the asset model that could provide a more systematic approach to using it. This led to the publication 'Revitalising the evidence base for public health: an asset model' in 2007 which was my first attempt to summarise the main ideas and challenges to its use in public health.

♦ How could we work on a balance between risky and positive factors (assets) in our communities? Is it possible to talk about a 'risk-free community'?

The asset model (AM) was first proposed to challenge public health to work differently with local communities, so that people could make best use of their individual existing strengths and the strengths of others (individuals or organisations) to solve health challenges in a positive way. The argument was that too much emphasis had been placed on 'fixing' the problems of the most vulnerable rather than professionals creating the conditions for health. The model also stressed that it needed to work in combination with the more traditional risk-based approaches as it was unrealistic to think that communities could ever be totally free of risk. It is important to see the AM as an approach which facilitates the co-production of health by building trust between local communities and professionals. Promoting well-being is central to the model but it can also be used to support the reduction in risk taking problems such as smoking. In this scenario, local communities work with professionals to provide joint solutions to removing barriers to giving up smoking.

♦ Some critics of the model state that if the asset model works (the community has capacities to manage itself), it will not be necessary for the government to get involved in the community. What do you think?

By definition, the asset model is about building different partnerships which are based on trust and equity in decision making for local solutions to health promotion. A key principle is to encourage 'decision-focused multi-professional and multi-disciplinary working'. In other words a number of horizontal and vertical relationships need to be nurtured in a way that allows individual partners to understand the responsibility in the process of creating the conditions of health. Governments need to be involved to provide the necessary resources (assets) and conditions that support good community working. They may have to relinquish some of their power to local communities so that the latter has a feel of autonomy in the decision-making processes, but this is done through a process of building trust and social capital. Fundamentally asset-based approaches will fail if governments are not appropriately involved.

♦ Asset-based community development can reformulate community activities. At the Congress of Community Health Assets held in Granada in May 2017, asset mapping was discussed in depth. Is it only a fashion? Is it a change? Could it facilitate a common language among other sectors? What could we do to transcend the identifiable resources of mapping?

Asset mapping is a term and a key tool developed by the Asset-Based Community Development Institute to facilitate the process of building sustainable communities, recognising their strengths and potential. In the context of public health this would be to help identify specific health-related goals. The term whilst having a longer history with ABCD, is still relatively a new term in the lexicon of public health. It has become fashionable and there have been an increasing number of publications reporting on the findings of asset-mapping exercises. The AM summarises how asset mapping can be incorporated into a public health approach and highlights (as does ABCD) the importance of: starting with a community-led vision for health; identifying (mapping) existing assets in individuals, associations and organisations that could help realise that vision; and importantly to develop a process of connecting the assets mapped for a 'productive purpose'. Asset mapping as stated by ABCD is a methodology and all aspects of the methodology need to be followed in order for it to be a worthwhile process. What is often still lacking is an evaluation of that process in order that public health professionals can make the case that there

is an added value to the taking this approach compared to traditional approaches (those that implement interventions without appropriate community involvement and voice). The AM also emphasised that if we do not advance our ability to evaluate asset-based approaches, then the 'fashion' will eventually fade. Public health is increasingly required to demonstrate that it has a good 'return on investment' - i.e. the benefits gained (health or health related) – outweigh the costs and resources required to achieve them. Asset mapping needs to be contextualised into an economic framework that is now central to all public health work.

The process of asset mapping can support effective partnership working as it allows us to identify all those parties (individuals and /or organisations) who have a role to play in the health development process and to make explicit the part they need to play to bring about success. If the process is done well then it can contribute to more connected and equal societies that are able to share power in decision-making processes so as many people as possible are able to succeed with their health-related goals.

♦ Another important topic was how we could achieve real participation in community activities. What do you think about it?

There is an increasing international policy imperative for health and their related professionals to find effective ways of involving the people they serve in all aspects of the health-development process (from developing interventions, to providing insights into how best to implement them and supporting their evaluation). It has been argued that higher levels of involvement will have greater impacts on health and related outcomes (including becoming better connected to others; being able to easily access available services and to overall health and wellbeing). There are many guides that have been produced by national and international public health agencies that aim to support professionals in finding the best ways of supporting meaningful involvement. One such example is that produced by the National Institute of Health and Social Care Excellence (NICE) in England. Their guidance on community participation outlines a series of evidence-based recommendations that help professionals avoid the pitfalls sometimes associated with the involvement process. For example, don't assume that everyone wants to be involved; ensure that different cultural perspectives are taken on board when thinking about solutions; find ways of making it easier for people to get involved; and ensure professionals are trained appropriately to engage with local communities.

In addition, it is important to note that it is not an easier process, it requires resources and importantly it takes time to build trusting relationships.

♦ You have good links with Spanish professionals working in community health. Please share your experiences and thoughts with us so that we can achieve a better network for professionals working in this field.

I have had the pleasure to work with a number of Spanish colleagues who I would now consider to be experts in asset-based working. My collaborations include experts from the Andalusian School of Public Health in Granada, Consejería de Sanidad de Asturias, the University of Seville and Generalitat Valenciana. In addition to being experts in the theory methods and practice of asset-based working, they are all passionate about making a difference to the lives of people they serve. This has to be starting point for this type of approach to be a success. In my experience, professionals who potentially have something to offer in making asset-based working a reality, fall into three categories: those people who are already working with it but might need further support and training; those people who are interested but need to know more; those people who are disbelievers, either because they have been involved previously and have had a bad experience or they just don't sign up to the fundamental philosophy. The most hopeful way of ensuring asset-based working is impactful is to find ways of making it 'mainstream' to the whole health and health care system. In other words, it is seen as more than an interesting project that is time and resource limited, rather it is embedded into a strategic approach and is known as the way we do things. My view is that there is sufficient experience in Spain now to move outside of the network of people who are already signed up to the approach and to find innovate ways of engaging with the 'disbelievers'.

♦ Finally, we would like this journal to become a reference for the people who want to promote community development. Could you please help us to take some steps to achieve it?

As I have already stated, one of the biggest challenges to improving our understanding of the benefits of investing in the asset approach is ensure we can better evidence the return on investment. In part, this relies on our ability to get things published. I think it's true to say that the scope of many health related journals is narrowly defined within the context of deficit models which focus on removing or minimising the impact of risk- taking behaviours. Also, despite the idea of mixed method approaches becoming more well known and practised, many journals are still dismissive of 'softer' ways of evaluating public health work.

What the asset-based approach needs is a journal that will champion the principles of the asset model and encourage a multi-disciplinary author and readership. That way, we are more likely to advance our knowledge of what works (and what does work), for whom and in what context.

What the asset model is really trying to do, is to ask health professionals to stand outside the usual realms of working to ensure that their activities can make a real difference to people's lives – particularly the most vulnerable.

Volver

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Mensaje

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