BU Pardee School of Global Studies
The Frederick S. Pardee Center for the Study of the Longer-Range Future

041

JUNE 2021

ISSUES IN BRIEF

Engaging Communities Through the Arts: A Proposed Framework and Model in Public Health Initiatives

Marial Williams is a violinist and occupational therapy doctoral candidate at the Boston University College of Health & Rehabilitation Sciences: Sargent College. She has experience in both the arts and healthcare sectors, and her work primarily focuses on musicians' wellbeing, health literacy, and health education.

www.bu.edu/pardee

Marial Williams

Public health is a shared, global responsibility, but the efficacy of public communication to increase adherence to public health initiatives is often mixed (Ordway 2020). As travel becomes more feasible for the majority, as people live further from their original homes, and as multiracial and multiethnic families and friendships become more prominent, the world becomes smaller and public health concerns become larger and increasingly global. This has been seen in the COVID-19 pandemic, where our very connected world has been faced with a shared public health challenge, but differing cultural and societal views or backgrounds have produced inconsistent and ineffective responses. Looking towards a future where the public is so diverse and yet health challenges are shared, more effective approaches are needed to connect people from varying cultures and communities to public health solutions in ways that are accessible, helpful, and meaningful. The following explores how community engagement through the arts may be a way to further these public health campaigns. More specifically, this work presents the Culture of Health framework and Multisensory Multilevel Health Education Model as two foundational methodologies that may guide future practice. Used together, they entwine the arts, health, culture, and community towards a common purpose.

Two Programs as Models for the Future

Currently, the body of research on engaging communities in public health through the arts is limited by a lack of scientific rigor in programming paired with a lack of recognition for the arts as a mechanism for engagement (de Quadros 2017, 16-18). There are various examples of the arts being haphazardly applied to public health campaigns as a supplement, while there are few examples of the intentional use of the arts as a way to bring communities together towards public health solutions. However, at least two examples of engagement through the arts exist in public health. The first is a program in Peru, the Arts for Behavior Change (ABC) Program. This music- and theatre-based program focused on improving personal hygiene to slow the spread of diseases and infections including pneumonia, diarrhea, and skin diseases (Pleasant et al. 2015, 60). The second is a program in New York titled Hip Hop Stroke (HHS),

focused on helping families identify symptoms of stroke and on lowering the time between identifying symptoms and seeking medical care (Williams and Noble 2008). These programs were identified as being different from the programs that came before them as they had scientific rigor within their development and implementation, had theory/evidence-bases, and used the arts at the forefront of their programming rather than only as an enhancement to the programs. Both showed improvement from their pre- to post-measures, and shared ten defining components detailed in the table below. While not all of the components are unique to arts programs, each component was incorporated into the programming through the arts.

Table 1: Components of Community Public Health and Arts Campaigns

Component	Features of Component
Interdisciplinary team	• Clearly defined roles of team members (whose input should hold equal weight) • Diverse backgrounds and points of view (i.e., insiders and outsiders of the community of focus, academics, and artists)
Science/evidence-backed foundation	• Evidence guided recommendations that are specific to the population and health challenge
Community-respected artist	• Involvement of a respected celebrity and/or person belonging to the existing community
Multimedia delivery	• Multiple arts mediums: music, visual arts, dance, etc.
Evidence the art form is relevant to the community	• Preliminary as well as ongoing research and community report to confirm relevancy and efficacy
Multidirectional communication	• Learning by teaching: community members teach each other • Ongoing discussions and dialogues between community and programming developers
Use of narrative and storytelling	• Character(s) with whom the community of focus relates • Opportunities for the community to share or add their own stories and personal narratives
Trust-building	• Implementation over a period of time (not “one and done”) • Active involvement of community (including in development) • Delivered in a trusted setting or context • Optional participation
Health literacy focus	• Ensuring and checking understanding • Using language that is not overly scientific or confusing
Artifact (take away piece)	• Objects or materials that reinforce information and/or serve as a cue/reminder to a targeted health behavior • Materials that are useful in helping disseminate the information to other community members

Source: Data adapted from Pleasant et al. 2017, 54-64; Williams and Noble 2008, 2809-2816; Williams and Swierad 2019, 872-888.

Challenges to Current Programming

One challenge in creating programming such as the ABC and HHS programs is that there is not an established foundation to build upon. Unlike other health interventions, there are not models or theories that guide practice in public health initiatives that engage communities through the arts (Brunton et al., 2017). However, the components identified between these two programs may be more readily achieved through the combined use of the Culture of Health framework and Multisensory Multilevel Health Education Model. Used together, the framework and model can guide program developers towards more efficient and effective programming that is meaningful to specific communities and is inclusive of different belief systems and ways of life. The framework and model themselves are further discussed below.

Culture of Health Framework

The Culture of Health Initiative by the United States-based Robert Wood Johnson Foundation (RWJF) recognizes the importance of culture in public health and puts the community at the forefront of the process to reduce health disparities, seeking to create an overall "culture of health" (RWJF 2016, 5-6). The development of the framework was evidence-based and purposeful, including the creation of a model of factors that drive health disparities and social determinants of health, a logic model that guides the relationship between drivers and outcomes, and an asset-based approach to community development (21-25). The framework is built on the assumption that asset-based community development "...must be undertaken in and by the community for real health investments to be realized..." and that there must be "...understand[ing] from the beginning that [program developers] will be more effective if they can work *with* the community, not on *behalf* of the community" (21). The framework also addresses measurement of outcomes, and provides guidelines for measurement, which is especially important in demonstrating the efficacy of programming (29).

The overall framework aims to improve population health, equity, and wellbeing through changing the "culture" of the population to sustainably support and promote health in the future. Towards this aim, the framework identifies four action areas: [1] making health a shared value; [2] fostering cross-sector collaboration to improve wellbeing; [3] creating healthier, more equitable communities; and [4] strengthening integration of health services and systems (RWJF 2016, 6).

The first action area, making health a shared value, prioritizes health in community decision making and expectations (RWJF 2016, 48). This action area focuses on a community's health beliefs, instilling the values that one's health affects others' and the health of others affects oneself, and increasing awareness about how the community's physical and social environments impact community health. The use of art to engage the community is in congruence with this action area, as using art to express and further values within a community is not a novel concept. Programs can instill health as a shared community value through the use of arts mediums that are already shared and valued within the community. During program development, community members may be present to confirm that the art form or medium is relevant within the community, as well as to develop and edit the art as the program progresses (Pleasant et al. 2015, 55-57). The idea of community members being as actively involved in program development and

"Programs can instill health as a shared community value through the use of arts mediums that are already shared and valued within the community."

implementation as the professional disciplines involved in the program leads into the second action area, fostering cross-sector collaboration.

Cross-sector collaboration is inherently done within public health and arts interventions. The arts additionally foster the availability of options for cross-sector work. When conceptualizing interdisciplinary arts work, it is worthwhile to recount the ideas of the philosopher John Dewey, who argued that the arts are too often separated from the rest of society as if they are an addition rather than an integral part of the whole (Leddy 2006). Current arts interventions do not yet fully benefit from cross-sector collaboration, but with more frequent and intentional interactions between program developers, Dewey's vision of the arts in society may be more fully realized. The same concept may be applied to health, which is an active and present factor in all domains of our lives, including domains outside of medical settings. In concordance with the first action area, the overlap of health into multiple domains requires that it be instilled as a value rather than viewed as an isolated behavior within a specific context. Consequently, health initiatives need a team that is ready to comprehensively address health from multiple angles, and a comprehensive medium that engages people and easily translates to the different aspects of their lives (de Quadros 2017, 16).

The third action area is to create healthier and more equitable communities. This may only be accomplished if communities are receiving equitable health information and there are not large disparities between communities in health literacy (Pleasant et al. 2015, 54; RWJF 2016, 43). Marginalized communities more often experience lower health literacy rates, adding to distrust in institutions and perpetuating cycles of health disparities when preventable diseases are not prevented (Chen et al. 2018, 725). This may be minimized by shaping an arts intervention's goals to focus on engaging the community in a dialogue, identifying existing gaps in health literacy, and supporting the community in finding science-backed information. Previous programs have shown how the arts encourage open dialogue that avoids overly scientific language or traditionally structured and formal health conversations (Pleasant et al. 2015, 55-56; Williams and Swierad 2019, 875). The arts also enable the diffusion of ideas and concepts throughout the community, when participants share information with other community members outside of the original intervention (Williams and Swierad 2019, 873). Equitable solutions may additionally be encouraged when there are opportunities for all types of community members to contribute to the conversation and the solution.

> **"Cultural tailoring through the arts to increase access of information... might be the greatest contribution arts programming has to offer public health."**

The last action area of the Culture of Health framework is strengthening the integration of health services and systems. The framework states that this type of integrated health system would "...address interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes" (RWJF 2016, XXV). The arts, and specifically music, have already been incorporated within each of these fields (i.e., medical — music lessening pain in cancer patients; social — music bringing people together such as in church choirs; developmental — music encouraging positive neonatal development; behavioral — music calming those suffering negative mental health symptoms; educational — music expressing concepts and aiding in memory of information; and financial — music helping to raise funds for health and community challenges). The broad spectrum of needs in health systems clearly calls for the involvement of varying disciplines within interventions,

and looking at these many examples, it is clear that the arts can successfully help answer that broad spectrum of needs when they are intentionally employed. While this interrelated nature of the problems and solutions has largely been addressed above, this action area adds that the integration of services is dependent on access. The framework would be particularly well applied within arts programming that enables access for a greater number of individuals. Cultural tailoring through the arts to increase access of information to groups of individuals that may not traditionally be reached might be the greatest contribution arts programming has to offer public health.

Multisensory Multilevel Health Education Model

While the Culture of Health framework acts as an overarching and thematic guide to interventions, the Multisensory Multilevel Health Education Model (MMHEM) more specifically outlines what a program looks like in practice. The MMHEM was developed with a theory-base, having influence from foundational theories in motivation and health behavior (the "why" of health education), social and ecological theories (the "who/where" of health education), and the 'edutainment' approach (the "how" of health education) (Williams and Swierad 2019, 873). The MMHEM has three main domains: art, culture, and science. Each domain is made up of subdomains that include actions and qualities that should be present within interventions, leading to knowledge and behavior changes within the community of focus.

For the domain of art, the model suggests programming that includes multiple art forms which are stimulating visually, auditorily, tactilely, and kinesthetically. The medium(s) should tell a story that is relevant to the community of focus and may be highly interactive, such as incorporating games, acting, or virtual reality (Williams and Swierad 2019, 880).

For the domain of culture, the model suggests research within the community of focus and an ecological perspective on the role of art within the community's dominant culture (Williams and Swierad 2019, 883). For instance, a community may be more familiar, and consequently, more receptive to a specific genre of music. Additionally, music itself may hold a specific meaning and role within community life. This domain also recognizes how malleable the arts are to being adapted to culture. Program developers can include aspects that celebrate and signal to people's identities within the community by telling stories that people identify with, or giving people a chance to tell part of their own story through the arts (877). Developers should additionally consider the way a community communicates. The model suggests programs capitalize on the role of technology within a community, such as social media, and use technological platforms to increase the outreach of the program (877-878).

Within the last domain, science, there are three subdomains: Cognitive Strategies, Evidence-Based Methods, and Evidence-Based Outcome Evaluation. Cognitive strategy use within the arts may include both strategies for learning information, such as acting out a health behavior within a theatrical production, and strategies for remembering information, such as using a song as a mnemonic. Additionally, the use of cognitive strategies is more complex than just putting words to a tune. For example, in the Hip Hop Stroke program the song had repetitive hooks, rhymes, and an acronym to help support memory of the information. Cognitive strategies used in this way ensure greater impact of the information that is being relayed or discussed within the programming (Williams and Swierad 2019, 876).

The MMHEM then addresses the design of the programming, stressing Evidence-Based Methods and Evidence-Based Outcome Evaluation. The specific guidelines include performing

literature reviews, using best practice information, ensuring that outcome measures are both reliable and valid in the community of focus, and having a rigorous and well-recorded research design (Williams and Swierad 2019, 876). The model particularly emphasizes that program developers make sure content being furthered through the arts on health behaviors and knowledge is in congruence with previous scientific literature that is relevant to the community of focus. While these may be common guidelines within scientific fields, the model is innovative within arts interventions, which often lack the type of scientific rigor that is suggested.

It is worth noting that the HHS program informed the Multisensory Multilevel Health Education Model, and while the MMHEM is currently being replicated and reapplied in further contexts, data from those programs is not yet available. Despite this, the model pushes for more scientific rigor and creates a space for program developers to conceptualize the intersection of science, art, and culture. Additionally, while the domains are separated in the model, it is also clear that there is significant overlap between them that leads to a successful program. Art, culture, and science within these types of programs are dependent on one another, and further, when paired with the Culture of Health framework they support the creation and implementation of a program that engages communities in the development of their own solutions, by using the arts as a medium of communication, togetherness, and outreach.

Together Towards a Better Future

By using the Multisensory Multilevel Health Education Model and the Culture of Health framework, future public health interventions that engage communities through the arts may be more efficient and effective. The two complement each other, as Culture of Health provides direction in areas where the MMHEM is less explicit, and the MMHEM offers concrete actions to the more conceptual Culture of Health framework. Public health research has continuously reinforced the concepts found in the model and the framework, with both being a way for programs to communicate evidence and science-backed solutions to health challenges in a meaningful and community-relevant format. Programming that engages a community in solutions and uses art to promote collaboration toward those solutions ensures that everyone involved in the process is a stakeholder in the product. Programs created with a guiding foundation such as these may also be more replicable and testable in the future (Brunton et al. 2017, 12).

"Programming that engages a community in solutions and uses art to promote collaboration toward those solutions ensures that everyone involved in the process is a stakeholder in the product."

The framework and model clearly demonstrate a push toward more inclusive healthcare and more positive health outcomes for a "public" that includes marginalized communities that are often forgotten in generalized public health approaches. With a theoretical base and better documentation of processes, the framework and model are a powerful way to engage an increasing number of communities through the arts. Although these programs may focus on communities who are not as intentionally included within the "public" that public health claims to serve, these programs additionally benefit the total population. As we have seen in the COVID-19 pandemic, in a world that is so connected, what affects one community affects all other communities. To exclusively implement generalized initiatives that do not reach smaller communities within the total population is not only unethical and exclusionary, but also counterproductive.

While the World Health Organization (WHO) Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition," this declaration of health as a fundamental human right may only be realized when public health initiatives reach the full public, and the full public may only be reached when all communities are more intentionally included and engaged (WHO 1946, 1). As artists, as public health officials, as educators, as policymakers, and as community members, we are all stakeholders within the health of our society, and the health of our society reciprocally determines our own individual health. "Health" is present in everything we do and experience in our everyday lives, and much of health is affected by variables that are far outside of the healthcare sector. Despite many believing that health is the responsibility of healthcare workers and that art is the responsibility of artists, these sectors are intertwined (de Quadros 2017, 27-28). Art is ingrained in our everyday lives as humans, and examples of human creation and expression are everywhere. The unification of the arts and health towards a common purpose is not idealistic, but necessary and logical.

> "...much of health is affected by variables that are far outside of the healthcare sector."

While current literature has retrospectively applied frameworks, models, or theories to public health interventions that engage communities through the arts, application should happen on the front end of intervention rather than on the back end (Brunton et al. 2017, 11-12). With complex public health issues that are impacted by a multitude of factors, this will ensure that interventions are answering the complexities of the issues from the start. Additionally, the intersection of arts and public health cannot be fully realized until it is codified within the literature. Programming can only be furthered if researchers and others involved in implementation think about multifaceted approaches that effectively integrate the work of multiple individuals. Greater consistency in terminology, language, and methodology promoted by the use of the Culture of Health framework and Multisensory Multilevel Health Education Model is one way to encourage this consistency, ensure comprehensiveness of solutions, and build credibility that furthers the efficacy and efficiency of interventions promoting sustainable public health solutions for communities in the future.

References

Brunton, Ginny, James Thomas, Alison O'Mara-Eves, Farah Jamal, Sandy Oliver, and Josephine Kavanagh. 2017. "Narratives of Community Engagement: A Systematic Review-derived Conceptual Framework for Public Health Interventions." *BMC Public Health* 17: 944-959. https://doi.org/10.1186/s12889-017-4958-4.

Chen, Xuewei, Jennifer L. Hay, Erika A. Waters, Marc T. Kiviniemi, Caitlin Biddle, Elizabeth Schofield, Yuelin Li, Kimberly Kaphingst, and Heather Orom. 2018. "Health Literacy and Use and Trust in Health Information." *Journal of Health Communication* 23, no. 8: 724-734. https://doi.org/10.1080/10810730.2018.1511658.

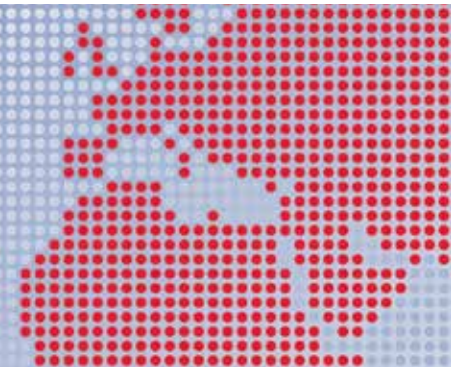
de Quadros, André. 2017. "Music, the Arts, and Global Health: In Search of Sangam, its Theory and Paradigms." *Journal of Folklore Research* 54 (1-2): 15-29. https://doi.org/10.2979/jfolkrese.54.2.02.

Leddy, Tom. 2006. "Dewey's Aesthetics," In *The Stanford Encyclopedia of Philosophy (Summer 2020 Edition)*, ed. Edward N. Zalta, Section 2.2. https://plato.stanford.edu/archives/sum2020/entries/dewey-aesthetics/.

Pardee School of Global Studies
The Frederick S. Pardee Center for the Study of the Longer-Range Future

Boston University
Pardee House
67 Bay State Road
Boston, MA 02215 USA

pardee@bu.edu
+1 617-358-4000 (tel.)
+1 617-358-4001 (fax)
www.bu.edu/pardee



Analysis for a better tomorrow, today.

The Frederick S. Pardee Center for the Study of the Longer-Range Future *is an interdisciplinary research center affiliated with the Frederick S. Pardee School of Global Studies at Boston University. It conducts interdisciplinary and policy-relevant research on a wide rage of issues that contribute to long-term improvements in the human condition. Through programs of scholarship and outreach, the Pardee Center works to disseminate the collective knowledge and experience of scholars and practitioners in an effort to ensure that decisions made today lead to better outcomes tomorrow.*

bu.edu/pardee
pardee@bu.edu
(617) 358-4000
@BUPardeeCenter
@BUPardeeCenter
@BUPardeeCenter
@BUPardeeCenter

Ordway, Denise-Marie. 2020. "How We Can Improve Public Health Messaging About COVID-19." *Journalist's Resource.* April 28, 2020. Accessed April 16, 2021. https://journalistsresource.org/economics/public-health-messaging-coronavirus/.

Pleasant, Andrew, André de Quadros, Maura Pereira-Leon, and Jennifer Cabe. 2015. "A Qualitative First Look at the Arts for Behavior Change Program: Theater for Health." *Arts & Health* 7 (1): 54-64. https://doi.org/10.1080/17533015.2014.930916.

RWJF (Robert Wood Johnson Foundation). 2016. *Building a National Culture of Health: Background, Action Framework, Measures, and Next Steps,* by Anita Chandra et al. 2016. Santa Monica, CA: RAND Corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1199/RAND_RR1199.pdf.

Williams, Olajide and James M. Noble. 2008. "'Hip-Hop' Stroke: A Stroke Educational Program for Elementary School Children Living in a High-Risk Community." *Stroke* 39 (10): 2809-2816. http://dx.doi.org/10.1161/strokeaha.107.513143.

Williams, Olajide and Ewelina M. Swierad. 2019. "A Multisensory Multilevel Health Education Model for Diverse Communities." *International Journal of Environmental Research and Public Health* 16 (5): 872-888. http://dx.doi.org/10.3390/ijerph16050872.

WHO (World Health Organization). 1946. *Constitution of the World Health Organization.* WHO 1-18: 1946. New York. https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1.