Children’s perceptions of strategies for resolving community health problems

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SUMMARY

We examine children’s perceptions of the strategies they would use to resolve community health problems. Qualitative analysis using a grounded theory approach showed that 9- to 10-year-old children could conceptualize a range of solutions to hypothetical community health problems. Children’s responses reflected an egocentric perspective, one that was centered on self and peers acting on short-term solutions to the immediate problem. Less frequently, children conceptualized broader structural interventions aimed at removing the problem altogether. Children could name resource persons including their friends, family, school personnel and other people in the community. However, outside of their family and peers, their knowledge was non-specific, i.e. it is doubtful that they would actually be able to access the resources. In light of our findings we discuss several important implications for future research. We note that children are interested in changing community conditions that affect their health. However, their recognition of their marginalized position in adult society and their perception that adults do not take them seriously may be significant barriers to their participation. We suggest that society must rethink the position and roles that are assigned to children so that their valuable potential is not lost.

Key words: children; community health; empowerment

INTRODUCTION

According to the World Health Organization (WHO), health promotion is the process of enabling people to take greater control over the conditions that affect their health (WHO, 1984). This definition has been influential in moving health promotion away from a lifestyle approach to one that focuses on the broader determinants of health and encompasses participatory socio-ecological approaches (McLeroy et al., 1988; Schwab, 1997). Within the WHO definition, there is a high profile given to community health, i.e. the social conditions that affect health, and to community participation as essential health promotion strategies (Naidoo and Wills, 1994). Although there are different levels of community participation, all of them recognize and build on the strengths of, and participation within the community, and assume that community members know best what their problems are and what solutions will work for them. Community workers or health professionals may assist community efforts through
facilitating, rather than initiating or directing initiatives.

Implicit in the WHO definition is the concept of empowerment, which is viewed as an enabling participatory process through which individuals and communities take control of the conditions that affect their lives [see, for example (Rappoport, 1984; Rappoport and Hess, 1984; McKnight, 1985; Powell et al., 1988; Bracht and Tsouros, 1990; Wallerstein, 1992; Israel et al., 1994; Rissel, 1994; Robertson and Minkler, 1994)]. At an individual level, it is assumed that participation builds personal skills in decision-making and social competence that includes assertiveness, effective communication and cooperation. At a community level, it is expected that participation will lead to community capacity to foster a more supportive physical, psychological and social environment [see, for example (Labonte, 1994)].

Within the field of health promotion, children have not been much encouraged to think about conditions that affect their health and how to change such conditions (Jensen, 1994). Most health promotion initiatives and health education programmes have been based on the notion that children must develop, on a personal level, healthy lifestyle behaviours. Policy documents typically address the health needs of children in terms of directives of what must be done for children, not with children (Hart-Zeldin et al., 1990). Only in recent years has there been adult support for giving children a say about the social conditions that affect their lives. The United Nations Convention on the Rights of the Child (United Nations, 1991) is the first international document to recognize that children should be allowed to participate in decisions that will have an impact on them. The Canadian policy document National Vision and Goals for Child and Youth Health in Canada placed the enhancement of involvement of children and youth in creating, maintaining and improving their health as its first goal (Canadian Public Health Association, 1995). The document noted that youth involvement should not be superficial. It argued that young people are articulate and ready to participate in their communities. At the same time the document noted that meaningful involvement will not occur unless institutional structures and policies support it. The Canadian Council on Social Development included youth in a community consultation process in order to assess the health and well-being of young people, and concluded that it was extremely important to listen to youth’s own articulation of their concerns (Canadian Council on Social Development, 1998). The policy initiatives noted above are supported by a growing research literature that argues for the importance of understanding how children themselves view their place in society, in terms of their own constructions of their needs, relationships and contributions [see, for example (James and Prout, 1990; Kalnins et al., 1992)].

CHILDREN’S PERSPECTIVES ON THE COMMUNITY

Reports of health promotion programmes in community, and especially school settings, have shown that children are both interested in community health problems and wish to participate in their resolution. When children have been asked to respond to questionnaires, which ask them to think of places and things in their community that they associate with adjectives such as dirty, safe, quiet, unfriendly, beautiful, ugly or dangerous, they can readily identify community conditions related to these descriptions. In addition, children can draw a picture of their ideal community, or point out to a facilitator areas in their community that are healthy and unhealthy (Pollack et al., 1991; Kalnins et al., 1994).

Many studies reporting youth participation in community initiatives have emerged in the last decade. In these, the youth have been shown to be a substantial community resource or asset (Moseley, 1995; Delgado, 1996; Finn and Checkoway, 1998). For example, high school students have mobilized themselves to gain financial and political support for after-school music, art and tutoring activities (Jermaine et al., 1997). Children as young as 9 years of age have joined with adults and mobilized action around issues such as drug abuse (Kelley, 1995; Delgado, 1996), gang activity (Torres, 1998), and the development of play spaces (Salvadori, 1997) and safe spaces (Meucci and Redmond, 1997). Reports from European Health Promoting Schools (HPS) projects (Macdonald and Ziglio, 1994), and Canadian Healthy Schools (HS) projects [British Columbia Ministry of Health and Ministry Responsible for Seniors (BCMH-MRS), 1993] amply demonstrate that children can conceptualize and participate in improving
conditions within their school, their school neighbourhood and the community at large. In HPS/HS schools, children participate in shared decision making with the school administration regarding issues that affect their physical, social and emotional health. The design and implementation of the activities involves collaboration between the students, teachers, parents and other resource persons in the community. Both the process and the outcome are seen as important in creating supportive environments that foster a sense of well-being and health, that build personal skills, and that strengthen the collaboration between schools and communities (Macdonald and Ziglio, 1994).

The HPS/HS idea has resulted in a wide variety of projects. A survey of projects in 600 schools in British Columbia shows that projects address teacher–student, student–student and school–parent relationships, safety, nutrition, multiculturalism, community safety and many other issues. Projects undertaken show that children are also aware of the broader community and global issues such as reducing pollution through proper sewage treatment, noise reduction, and conservation of resources through recycling programmes. The wide variety of projects undertaken indicates that children have concerns about their school community and the broader community, and welcome the opportunity to do something about them (BCMH–MRS, 1993).

The projects described in the existing literature demonstrate that children can be involved in processes in which they become change agents in their communities. They can engage in assessments of their needs, identify priority issues, and engage in the design and implementation of activities to make the desired changes. These findings, seen in the context of the emphasis that health promotion places on community participation, raise the question of whether children should explicitly be taught to seek a voice and be encouraged to be agents of social change in their communities. On the one hand, for those who subscribe to the notion of empowerment and children’s rights, such roles may be appealing on the grounds that participation helps children to develop a sense of determination and citizenship and ensures that their needs are met [see, for example (Hart et al., 1997; Meucci and Schwab, 1997; Galbraith et al., 1999)]. On the other hand, for those who are concerned with children’s protection, ideas regarding children’s empowerment and active participation may represent giving unnecessary and inappropriate responsibilities to them.

**STUDY OBJECTIVE**

In this study, we explore how young children think about themselves in relation to community problems that affect their sense of well-being and health. The data presented in this paper are drawn from a larger project in which 9- to 10-year-old children participated in a community development project (Pollack et al., 1991; Kalnins et al., 1994). As part of the evaluation of the impact of a community development project, we conducted semi-structured interviews with children about how they would deal with three hypothetical community problems, identified in the literature as community problems commonly encountered by children (Aldrich, 1987; Edmonton Board of Health, 1988; BCMH–MRS, 1993). The problems included broken playground equipment, having to deal with dogs that are not on a leash and having to cross a busy street. We addressed children’s perceptions of their role in resolving these problems by asking them how they would solve the problem. To understand better their perceptions about the resources they could access we asked them to explain who could help them. Finally, to gain insight into their perceptions about the effect of their actions, we asked them what would happen. From an in-depth qualitative analysis of their responses carried out within a grounded theory framework, we present a conceptual model of children’s perceptions about their role in resolving community health problems as a guide for further debate and research concerning children’s involvement in community health initiatives.

**METHODS**

**Participants**

The data presented in this paper were collected from three classes of school children in grades 4 and 5. One class included 24 children who had participated in a community development process throughout the school year [see (Pollack et al., 1991; Kalnins et al., 1994) for a description of this programme]. The other two classes (n = 27
and \( n = 21 \) included children from two schools in the surrounding neighbourhood who had not been part of the programme. In total, 72 children participated (35 girls, 37 boys). All of the children came from low-income families, many of which were headed by a single parent. The student body in each of the schools was multiracial and multicultural.

### Procedure

Children participated in interviews structured around the following three vignettes.

(i) Imagine that the swings and slide in the only playground around are always broken so that you cannot use them.

(ii) Imagine that on your way home from school you have to pass a house with a mean dog who is never on a leash.

(iii) Imagine that in order to get to the community centre you have to cross a street that is so busy that you and your friends are afraid to cross it.

After each situation was read aloud, the following questions were asked.

(i) What could you do about this problem?

(ii) Who could you get to help you?

(iii) What could they do to help you?

(iv) What do you think would happen?

Children were prompted with ‘Is there anything more?’ and ‘Anyone else?’ to encourage them to answer as fully as possible.

Each child was interviewed privately by one of five trained interviewers. Parental and child consent was gathered through letters sent to the home and returned to the investigators. In addition, each child was asked at the time of the interview if he or she wanted to participate. Interviews were semi-structured, lasting 10–20 min. They were audiotaped and transcribed verbatim for analysis.

The interviews were conducted shortly after the beginning of the school year (October) and shortly before the end of the school year (April) as part of an evaluation of the impact of an intervening community development project in one of the participating classes [see (Pollack et al., 1991; Kalnins et al., 1994) for a description of the community development project]. Since analysis of themes indicated no substantial differences among the three classes of children or between the interview at the beginning of the year and the end of the year, all interview data were pooled in order to present the fullest possible range of the children’s conceptualizations about community health problems and their role in resolving these. This enabled us to develop a model based on the largest database possible.

### Data analysis

We chose a grounded theory approach (Glaser and Strauss, 1967) to analyse data. This is a qualitative research method designed to aid in the systematic collection and analysis of data leading to the construction of a conceptual model (Creswell, 1998). Typically the data are collected through unstructured interviews, which yield a rich comprehensive narrative description that represents the subjective perspective of the participants. The data are analysed inductively, without preconceived response categories or hypotheses (Glaser and Strauss, 1967; Rennie et al., 1988).

In this study, we used semi-structured interviews about hypothetical situations in order to elicit children’s responses to community problems. This approach has been successful in earlier studies of children’s perceptions of community health issues (Edmonton Board of Health, 1988).

Data analysis involved several steps. First, the transcripts were read and re-read in their entirety to acquire familiarity with the data. While the transcripts were read, notes were made to keep track of ideas, hunches and interpretations. Secondly, open coding of the transcripts was carried out. In this process all phrases or sentences in the transcripts relevant to each question were grouped into categories. These categories were then systematically compared and grouped into increasingly complex, inclusive and abstract categories. The sorting of statements into categories and the grouping of categories into themes was conducted by the authors (C.H. and P.B.), in conjunction with peer debriefing with two other authors (G.Q. and R.L.). Disagreements about category assignment were discussed and resolved through consensus in an ongoing process of clarifying the category definitions. It was not possible to return to the classroom to validate the interpretation of the data through further conversations with the children.
RESULTS

Two major approaches were identified from children's responses to the questions posed to them about the three hypothetical community health problems; we have termed these approaches ‘actions around the problem’ and ‘actions on the problem’. Specific strategies underlying each of these approaches as well as illustrative examples of children's statements related to each are listed in Table 1.

‘Actions around the problem’ includes several strategies in which children proposed that they would adjust their behaviour to the situation. The specific strategies within this approach included adapting behaviour to the situation (e.g. ignoring the mean dog), choosing alternative courses of action (e.g. go to another playground) or avoiding the situation (e.g. I would never go there again). Children also stated that they could get out of the situations by creating a distraction or diversion (e.g. get the dog to fetch a stick) or by utilizing resources that they assumed would be present (e.g. ask a policeman for help in crossing the busy street). We labelled these strategies as ‘actions around the problem’ because the end result would be that the problem could be resolved for the child at an individual level. However, in these instances the situation causing the problem would remain and the same situation could occur again.

‘Actions on the problem’ includes strategies in which children said they would personally resolve the problem (e.g. I would fix the swings), directly confront the person responsible (e.g. tell the owner to put the dog on a leash), ask for a new resource (e.g. ask for a crossing guard) or give the problem high public visibility through petitions (e.g. send a petition to the government). These strategies represent a structural solution to the problem; i.e. the action proposed could resolve the problem for the child. It could also potentially resolve the situation in the community so that it does not reoccur.

Children identified a variety of resources they could use to help them deal with community problems. In addition to relying on themselves, they named personal and community resources (Table 2). Personal resources included family, friends, peers, close neighbours and familiar adults. Community resources included teachers and the principal of their school, several community authorities such as the crossing guard or housing authority, the community at large and its organizations, random individuals such as a passerby, or a ‘lady driving’ or ‘anyone bigger’. Children were also aware of various community service personnel including police and fire fighters, ‘workers’ such as utility company employees, a ‘playground fixer’ or ‘a repairman’, and the government, including the mayor, the Premier, city hall or just ‘the government’.

Although the particular resource varied, there were similarities and patterns in the way that children described how they would use resources. For example, with respect to actions around the problem, children’s explanations about resources included both working alone and using personal and community resources. For actions on the problem, children rarely said that they would work alone.

Children’s responses also showed that they perceived that resources could be used in different ways. Resources could be called on to work with them, for support or as direct help. For example, children suggested that their friends would help them fix the swings, or would provide ‘moral support’ when walking past the mean dog. In these situations, children expected to work together with the resource person to solve the problem. Alternatively, resources could be used for them, as mediators or agents to contact other resources. Children understood that they did not always have the power to influence resources or to achieve a desired outcome by themselves. For example, one child said ‘My mother could call the government for me because they will listen to big people’. Finally, children perceived that there were some people who could be called upon to resolve the problem on account of their job or social position. These resources worked at the child’s behest. For example, children suggested that a crossing guard could help them cross a busy street, or that the dogcatcher or pound could ensure that the dog was controlled.

With respect to the expected outcome of the solutions they proposed, children most often talked about the immediate short-term benefit to themselves. This was evident in responses such as ‘I would fix the swing and play with it’ or ‘I would get the crosswalk lady to put out her sign and then I would walk (across the street)’. Less frequently, children recognized that the solutions would benefit both themselves and the community. For example, one child suggested that a traffic light would help all children cross the busy street. The solution given was ‘Ask the school. The principal would say yes because she
### Table 1: Concepts underlying children’s responses to questions about what they could do to resolve health problems in their school neighbourhood

<table>
<thead>
<tr>
<th>Strategies: what could you do?</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action around the problem.</strong> The child proposes to adjust his/her behaviour to the situation. The end result is that the problem may be resolved for the child but the situation causing the problem still remains.</td>
<td></td>
</tr>
<tr>
<td>Adapts</td>
<td>The child proposes adapting his/her behaviour to the situation.</td>
</tr>
<tr>
<td>Uses alternative</td>
<td>The child suggests an alternate plan of action that circumvents the problem situation.</td>
</tr>
<tr>
<td>Avoids</td>
<td>The child avoids seeking any confrontation with the problem situation and does not identify an alternative plan of action.</td>
</tr>
<tr>
<td>Distracts</td>
<td>The child uses someone or something as a distraction or diversion. May protect self by putting someone else in danger.</td>
</tr>
<tr>
<td>Assumes resources available</td>
<td>The child’s solution to the problem involves an assumption that the appropriate resources are already in place.</td>
</tr>
<tr>
<td><strong>Action on the problem.</strong> The child seeks a long-term structural solution to the problem. The end result is that the problem may be resolved for the child and the situation causing the problem is changed.</td>
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</tr>
<tr>
<td>Fixes</td>
<td>The solution involves either the child or his/her designate repairing whatever is creating the problem.</td>
</tr>
<tr>
<td>Confronts</td>
<td>The child or his/her designate directly requests that the person responsible for the problem take appropriate action to alleviate the situation.</td>
</tr>
<tr>
<td>Seeks new resources</td>
<td>The child suggests implementing a programme or the use of a new resource.</td>
</tr>
<tr>
<td>Petitions</td>
<td>The child suggests that a petition would be a useful means to bring the problem to the attention of public authorities.</td>
</tr>
</tbody>
</table>

- ‘Walk and just ignore the dog and don’t run because the dog will chase you.’
- ‘Walk with friends who I can talk to about other stuff except the busy street.’
- ‘Maybe I could go to another playground.’
- ‘I wouldn’t cross there. I’d cross at the crosswalk.’
- ‘I would never go there again.’
- ‘I would never play there.’
- ‘My friend could do something. He could make the dog go fetch a stick and then you could cross.’
- ‘The other people could put something on the road to make them stop then I can go across.’
- ‘Pretend there’s a car crash at the corner and make them stop then I can walk across.’
- ‘You could press the button, the walk sign and make the cars stop.’
- ‘I would walk across [sic] the dog with a policeman.’
- ‘My friends and I could fix it.’
- ‘I would tell the caretaker to fix the swings.’
- ‘I could tell the owner to put the dog on a leash.’
- ‘Someone bigger, like a grown up, like your father, your mother, your uncle, could talk to the owner.’
- ‘Take your parents to the government and ask for a cross guard.’
- ‘I’d ask the school to put up a crosswalk. Mrs (the principal) would have to hire somebody.’
- ‘I can get a whole bunch of names and then I can send it to the mayor or somebody at the city to see how many people want that place fixed.’
- ‘We could get a petition and see if we could get a crossing guard.’
cares for everyone’. Some children recognized that others who would also benefit might be enlisted in the solution, e.g. ‘The people who would want to play on it would help to fix it’.

**DISCUSSION**

We have summarized our findings in a conceptual model (Figure 1). In the model, actions around the problem and actions on the problem are depicted as separate non-overlapping strategies to solve community problems. However, it should be noted that the same resources can be used within each strategy. We have linked the specific strategies and resources with a plus sign to indicate that both these elements are present in children’s thinking. The two outcomes indicate significantly different resolutions to a community problem.

Our model is not meant to imply that children deliberately think in a linear fashion about what strategy they would take and the resources they could call on. Typically models are drawn with arrows to show causal links between components (Earp and Ennett, 1991). We have avoided using arrows to denote linkages because our level of knowledge about children’s strategies for resolving community health problems is at a preliminary stage.

Our findings confirm that children can conceptualize health at a community level. It is notable that almost without exception, children proposed solutions to the hypothetical situations put to them. Among the 72 children who participated in the study, only a couple of them stated that they did not know what they would do about the problems we posed, or that they could do nothing. Clearly, children did not perceive themselves as powerless in their communities. Thus, in principle they could be involved in community-based activities. In the context of current health promotion practice, which focuses on community and capacity building (McKnight, 1985), and

<table>
<thead>
<tr>
<th>Resource category</th>
<th>Verbatim examples</th>
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</thead>
<tbody>
<tr>
<td>Self</td>
<td>‘I could fix the swing and play with it.’</td>
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<td></td>
<td>‘I could tell the owner to put a leash on him (the dog).’</td>
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<tr>
<td>Personal resources</td>
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<tr>
<td>Family</td>
<td>‘My mother could call the government for me because they will listen to big people.’</td>
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<td></td>
<td>‘Maybe I could tell my uncle to help to fix it back. He could buy new chains (for the swing).’</td>
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<tr>
<td>Friends/peers</td>
<td>‘They (other children) would cross the street with me to help me go.’</td>
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<tr>
<td></td>
<td>‘I can go get my friend and he can help me, because together we’re not scared of anything (the dog).’</td>
</tr>
<tr>
<td>Neighbours/familiar adults</td>
<td>‘We can go to a neighbour’s house and tell them to help to get to our house.’</td>
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<tr>
<td></td>
<td>‘Maybe I could call a neighbour who could help me.’</td>
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<tr>
<td>Community resources</td>
<td></td>
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<tr>
<td>School</td>
<td>‘You can get the caretaker to fix it … because they got lots of tools.’</td>
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<tr>
<td></td>
<td>‘Teachers. They can help put the things together, like wood and steel.’</td>
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<tr>
<td>Community authorities</td>
<td>‘A crossing guard could stop the cars for me.’</td>
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<td></td>
<td>‘First I would talk to the housing people. They can make the people that would fix it (the swing).’</td>
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<tr>
<td>Community at large/clubs</td>
<td>‘My friends. They could help me tell the neighbourhood and come together and talk about this.’</td>
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<tr>
<td></td>
<td>‘I could start a club and tell anyone who pays some money to buy some equipment to fix it (the swing).’</td>
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<tr>
<td>Random individuals</td>
<td>‘A lady driving.’</td>
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<tr>
<td></td>
<td>‘When people walk by, I might ask them to help.’</td>
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<tr>
<td>Law enforcers</td>
<td>‘Call the police.’</td>
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<td>Workers</td>
<td>‘The guarding people, the controlling people.’</td>
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<td></td>
<td>‘Find a worker man and tell him if he can fix it.’</td>
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<td></td>
<td>‘Call some engineers who can fix playgrounds.’</td>
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<tr>
<td>Government</td>
<td>‘If I could, I’ll ask the mayor.’</td>
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<tr>
<td></td>
<td>‘Inform City Hall to put up some lights.’</td>
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</table>
adult support for giving children a say about the social conditions that affect their lives (e.g. United Nations, 1991), health promotion strategies that seek to foster children’s sense of agency in health issues at a community level merit further examination.

There are several issues related to our findings that need further debate and investigation. Our findings showed that children’s solutions to the community problems were typically egocentric, or centered around self and peers acting on short-term solutions for the immediate problem. Less frequently the children conceptualized broader structural interventions aimed at removing the problem altogether. Furthermore, children presented a sense of considerable omnipotence and lack of assessment of risk. The solutions suggested, such as climbing the height of a set of swings in a public playground in order to fix the swings or confronting the owner of a mean dog, all involve risk and would not be congruent with the goals of most community health promotion efforts for children.

The egocentric response set of children in our study could reflect the concrete, egocentric thought characteristic of the cognitive development of children at this age (Piaget, 1952). It could also reflect the nature of the problems posed to them. Situations such as broken swings, mean dogs and busy streets are community problems that in real life children have to deal with personally and immediately. Whether children would be equally egocentric in their responses if presented with a broader range of situations, especially situations that are troublesome but do not require immediate personal action, requires further examination.

The egocentric stance of the children may also reflect children’s marginalized position in society and lack of direct experience with decision making about health, other than at a personal level. Within the field of health, children have not typically been given much encouragement to think about conditions that affect their health or how to change such conditions, because health education has been premised on the notion that children must develop, at a personal level, healthy lifestyle behaviours (Hart-Zeldin, 1990; Jensen, 1994). Thus, for children, the notion of themselves as agents having the power to change conditions that affect their health may be a foreign one. This possibility is suggested by

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### Fig. 1: Children’s perceptions of community health problem solving.

<table>
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<tr>
<th>STRATEGIES</th>
<th>RESOURCES</th>
<th>OUTCOME</th>
</tr>
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<tbody>
<tr>
<td>Action AROUND problem</td>
<td></td>
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<tr>
<td>Adapts</td>
<td>Self</td>
<td>Problem resolved but situation remains</td>
</tr>
<tr>
<td>Uses alternative</td>
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<tr>
<td>Assumes resources available</td>
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<td>Can’t solve</td>
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<td>Don’t know</td>
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<td>Action ON problem</td>
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<td>Initiates action</td>
<td>Community resources</td>
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<td>Petitions</td>
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Caputo (Caputo, 1999a; Caputo, 1999b) and Morrow (Morrow, 2000), who note that youth do not feel heard in their community. Alderson's survey of youth from 7-17 years of age in 250 schools in Great Britain and Northern Ireland found that young people wanted to be heard and respected, and to have more opportunities to share their ideas and suggestions (Alderson, 2000). Valaitis reports that youth perceive that adults think they lack competence and cannot be trusted (Valaitis, 2002). Clearly, young people perceive a significant power imbalance between themselves and adults in their communities. For children in our study, the power imbalance may have been exacerbated further by their low socio-economic backgrounds and experiences in their community.

Our findings showed that children can name resource persons, including their friends, family, school personnel and other people in the community. However, our findings also showed that children’s knowledge of community resources was vague, abstract and non-specific. Furthermore, children recognized their lack of power at a community level. For example, one child stated that ‘I would ask a grown-up to help me because sometimes they don’t listen to kids’. In community level health promotion activities, accessing resources is a key element that permits community members to share information and increase their capacity for action. Our findings suggest that without guidance children would not know how to access resources or they may not try to do so because they perceive that they will be unsuccessful.

Finally, our findings showed that children’s strategies typically focused on immediate short-term solutions. Rarely did they mention that their actions would help others who have the same problem or that it would prevent the problem from recurring. Thus, children did not appear to think explicitly in terms of solutions that address the conditions that cause the problem in the first place. While their perceptions may reflect the nature of the problems we posed to them, they do raise the issue of the extent to which, and conditions under which children can think about the good of a community and their role in effecting change. Furthermore, we have no information about children’s perceptions with respect to how quickly they think that community-level changes can occur. Children have traditionally been taught to conceptualize health as a matter of adopting healthy lifestyle behaviours. Implicit in the messages is that these behaviours can be adopted immediately if one wishes, and that they can be expected to yield relatively quick results physically, emotionally or socially. In contrast, community-based, collaborative problem solving cannot be expected to produce immediate changes and may not produce changes at all. Thus, there is the danger that children may have unrealistic expectations about what can be accomplished and become disappointed with lack of progress.

Although there is little knowledge at a conceptual level about children’s involvement in community-level health promotion, the practical experience of the European Network of Health Promoting Schools (MacDonald and Ziglio, 1994) and the Canadian Healthy Schools (BCHM–MRS, 1993) has shown that with adult support, children can become involved in community-based health promotion when the community is defined as their school. Children have shown that they are able to visualize how they would like their school to be, to identify problems they would like to modify, and to implement changes in collaboration with their teachers, parents and community. Our own work, however, in which children were asked to think about the community outside of their school, has shown that this was much more difficult. Children experienced difficulties identifying how they would work collaboratively outside of their cliques or friendship groups, and they needed assistance describing how they would access resources (Pollack et al., 1991; Kalnins et al., 1994).

It should be noted that the findings presented above are based on community conditions chosen by the investigators. Further study is needed to determine how children imagine and decide to resolve problems that they themselves identify.

RESEARCH AND PRACTICE CHALLENGES FOR CHILDREN’S INVOLVEMENT IN THEIR COMMUNITIES

It seem clear from the research reported in this paper, as well as from other examples that have been cited, that children are very interested in their communities and, if given the opportunity, are willing to become involved in changing community conditions to promote their own well-being. At the same time, our research suggests that children may have unrealistic expectations about what they can do, and also have insufficient
knowledge about available resources and how to access these. When coupled with their perception that they are not trusted and that ‘grown-ups run everything’ (Valaitis, 2002), it appears unlikely that children can actively engage in the community unless adults champion them. In a review of 200 community initiatives, Finn and Checkoway summarized the following four components that are found in successful community initiatives involving children (Finn and Checkoway, 1998). First, there is an acceptance of the idea that children can be competent community builders who can identify and solve youth problems at a community level. Secondly, mentor relationships with adults are present that help youth develop leadership skills. Thirdly, there are opportunities for the involvement of youth in committees and boards where decision making occurs. Finally, adults have skills that enable them to work with the youth in a mutually respectful manner. Taken as a whole, these criteria suggest that society must rethink the position and roles assigned to children so that their valuable potential to engage in community change is not lost.

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