Health Promotion and Empowerment: Practice Frameworks

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Health Promotion & Empowerment: Practice Frameworks

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Health Promotion and Empowerment: Practice Frameworks

Synopsis

This monograph asks and answers one question: How can professionals working under a rubric of health promotion engage in specific actions that are empowering? Its answer(s) to this question are based upon the author's personal reflections on six years of professional training workshops (1986-1992), involving over 2,500 community health practitioners in three different countries (Canada, New Zealand, Australia).

Three general approaches to health are identified: The medical, behavioural and socioenvironmental approaches. Each health approach contains a template of differing health conceptualizations, program strategies and success criteria. Several aspects of these templates are described and critiqued. Health promotion is defined as the socioenvironmental approach to health, and a model identifying socioenvironmental health determinants is sketched to illustrate **why** social justice and equity are important health concerns.

The monograph shifts focus midway to the concept of empowerment. A holosphere of empowering strategies from personal care to political action is presented. Health promotion is (or should be) characterized by efforts to **link** actions at these different social levels in some coherent way. Each of the five strategies (personal care, small group development, community organizing, coalition building and advocacy, political action) is discussed in some detail, with particular emphasis given to notions of community, community organization and community development.

The monograph weaves theory with stories. In doing so, it is neither a text nor a manual but an exploration of a potentially emancipatory professional practice. Although the monograph is subtitled, "Practice Frameworks," the models it presents are essentially useful shorthand graphics that emerged during workshop reflections on the who, what and why of health promotion in peoples' day to day professional work. The models are tools for reflection, not blueprints for planning.

About the Author

Ronald Labonte has worked in health promotion for 19 years at all three government levels. He has developed health programs on such diverse subjects as unemployment, poverty, contraception, child abuse, community economic development, workplace smoking, workplace health and safety, occupational stress, sexually transmitted diseases, empowerment and mental health, and healthy and sustainable communities. He is known for his work on linking professional practice with community development.

Ron has consulted to health authorities in federal, provincial and territorial governments in Canada, Australia, and New Zealand. He has also consulted to public health units, community health centres, labour union, AIDS foundations and social service organizations.

In 1986 he was visiting Fellow in Community Health at the Lincoln Institute of Health Sciences, Melbourne, Australia. In 1990, he was a Commonwealth Fellow and visiting lecturer at the University of Waikato in Hamilton, New Zealand, where he assisted in establishing that country's first graduate program in community health development. Ron had lectured at both the University of Toronto, Community Health Division, and York University, Social Sciences Division. He currently works part time as an education consultant in community development with the Toronto public health department, is a Member with the Centre for Health Promotion at the University of Toronto, and works privately as a community health consultant.

Foreword

Always provocative, always readable, always informative, Ronald Labonte challenges both the intellect and the conscience of health promotion practitioners.

What emerges from Labonte's notes, as from the naturalistic notes of Charles Darwin who also observed an evolving and adapting enterprise, is a reconstruction of the origin, historical development and diversification of the health promotion species.

The species of *homo santius promotium* has specialized its varieties on different continents – the American variety adapting to a materialistic environment with theories and practices of resource mobilization, the European variety adapting to the failed Marxist environment with "new social movement theory" and new strategies for emancipatory social change. Labonte characterizes The American variety of health promotion as having evolved a practice of survival of the fittest, literally at the individual level of fitness and figuratively in its community organization strategies of coalition building to gain superior strength and influence. The European breed has followed a survival pattern of species diversification, placing its emphasis on "identity formation" for social movements and collective action and on "everyday life networks" and civil society rather than seeking to seize formal state economic power (with the notable exception of the Green Party).

Labonte's probing notes guide the wary health promotion practitioners through this maze of evolutionary options, seeking a unity of theory and practice (praxis) by reflecting on why they do the things they do so that they can change and improve their professional practice. He weaves a path between the perils of neutralizing needed social conflict on one side and romanticizing "the community" as the solution to all health problems on the other. The path he finds leads to a health promotion practice that seeks to transform our institutions and organizations, because they will neither go away nor adapt adequately without conscious and concerted effort. Labonte gives health promotion an identity, a role and a *raison d'être* worthy of the hopes pinned to it by the Ottawa Charter and other policy declarations.

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Introduction

The field of health promotion has been upheaved in recent years. Old crops of clinical advice gave way to new hybrids of healthy lifestyles. These hardier strains proved insufficient for the human diet, and yet new buddings of healthy living conditions, with their polyphony of social justice and equity claims, began to colonize the crop rows. Much has been written describing the shapes and sizes of these plants, both old and new. Less has been written about their roots, the assumptions that bind them in the health field in the first place, and which determine how nurturing they may be to health promoters-as-harvesters.

This monograph is an effort to expose some of these roots. This monograph really asks and attempts to answer only one question: **How can professionals working under a rubric of health promotion engage in specific actions that are empowering?** Professionals and their organizations are the subject of this paper and not, except in passing, the individuals or groups with whom they engage. The monograph is based upon personal reflections on six years of professional training workshops (1986-1992), involving over 2,500 community health practitioners in three different countries (Canada, New Zealand, Australia). These workshops were critical peer reflections upon this monograph's one question and, while I offer a personal rendering of the workshops' learnings, and attempt to locate them within some useful critical theories, I do not claim sole authorship for any insights they may afford.

I begin with a brief discussion of health promotion history. This discussion identifies three general approaches to health: the medical, behavioural and socioenvironmental approaches. Each approach is treated as an ideal type. German sociologist, Max Weber, devised the notion of ideal types in his analysis of social structures. An ideal type is a stereotype, an exaggerated form that does not actually exist but which is useful as a conceptual category against which one's perceptions or findings can be analyzed.

Each health approach, in ideal-typical terms, contains a template of differing health conceptualizations, program strategies and success criteria. Several aspects of these templates are described and critiqued. Health promotion is defined as the socioenvironmental approach to health, and a model identifying socioenvironmental health determinants is sketched to illustrate **why** social justice and equity are important health concerns. I pay particular attention to how the experience of health and health concerns are constructed by different social groups, and how our own practice tends to be dominated by the reductionist features of the medical paradigm. In defining health promotion as a socioenvironmental approach, however, I do not mean to devalue the importance of the medical and behavioural approaches to health. I discuss these approaches as nested boxes, each one attempting to expand the repertoire of concepts, actions and consequences of its progenitor.

The monograph shifts focus midway to the concept of empowerment. A holosphere of empowering strategies from personal care to political action is presented. I argue that health promotion is (or should be) characterized by efforts to **link** actions at these different social levels in some coherent way. Each of the five strategies (personal care, small group development, community organizing, coalition building and advocacy, political action) is discussed in some detail, with particular emphasis given to notions of community, community organization and community development.

The monograph tries to weave theory with stories. In doing so, it is neither a text nor a manual. It is, instead, an exploration of a potentially emancipatory professional practice. While not complete, it is sufficiently broad in scope that most issues confronting health promoters are given some airing. There is no specific section on evaluation, and that is intentional. There is a regrettable tendency to section off evaluation from practice, as if it is somehow **separate** from acting in the world. This conveys the bizarre idea that good practice gives little heed to its impact. Rather, good practice is one of constantly reflecting upon and evaluating one's actions relative to one's intentions. In deference to this belief, facets of evaluation appear throughout the monograph as they apply to different and particular practice issues.

Although I subtitle this monograph, "Practice Frameworks," I do so with some reluctance. I do not believe the models I present function as planning devices, offering diagnostic or prognostic schema for a health promotion practice. There are many other good health promotion frameworks for that type of planning. The models I present are at best heuristics, useful shorthand graphics that emerged during workshop reflections on the who, what and why of health promotion. They are tools for reflection. You may create from them whatever blueprints for action work best in your own situation. And you have been warned: Those with a low tolerance for ambiguity and a high need for how-to fix-it manuals may be disappointed.

For those with a keen eye for gender issues, note that I use an alternating pronoun convention in this monograph. I find the she/he, his/her usage clumsy. Be advised that in alternating pronouns I do not necessarily imply that what follows a "his" or a "her" is a statement of gendered ways of knowing, or of doing things!

Ronald Labonte

January 22, 1993

Chapter One: Health Promotion in Recent Context

One could dig deeply into the past to bare many of the tensions this monograph describes. In Ancient Greece, the birth place of western medicine, Aesclypius the surgeon healer was flanked somewhat subserviently by the two nurses of health, Hygeia, the goddess of hygiene, prevention, good water and good food, and Panacea, the goddess of nostrums and cures. Apart from the sexist healing roles this presentation evokes (male as surgeon-"hero," female as nurse-"nurturer"), the ages'-old tug of priorities between health promotion (Hygeia) and disease treatment (Aesclypius) stands starkly. Hygiea herself was lesser ranked than her cure-all sister.

But it is with much more recent events that this monograph is concerned, specifically what might be called the pre- and post-**Ottawa Charter for Health Promotion** periods. This chapter summarizes these periods, using them as a base from which the three basic approaches to health – medical, behavioural and socioenvironmental – might be defined.

The Medical Approach

For much of Western history the workings of the body were poorly understood. Most people believed that sickness and health resulted from supernatural causes. Attempts to understand the workings of the body were often repressed by governments or religions as threats to their powers. This situation began to change dramatically in the 16th century, which ushered in the Age of Enlightenment. Over the past 400 years, our knowledge of anatomy, physiology, immunology, genetics, neurology and all the other reducible aspects of body functioning has grown with such rapidity that we now face ethical dilemmas created by our technical sophistication (e.g. reproductive technologies, life support systems, genetic engineering).

Our medical knowledge, while impressive, developed in a rather mechanical fashion. The body was conceived of as a machine, albeit a very complex and sophisticated one. A breakdown in this machine (a disease) required some intervention to fix it. For much of this century, our dominant concept of health has been dominated by the "disease (breakdown) – treatment (fix it)" model. Within this model, health is defined as "the absence of disease or infirmity," and a "health determinant" is that which causes disease. I say this is the **dominant** model because it is the one imbued with scientific, professional and institutional authorities. It is by no means the only model and does not describe how most persons experience their health.

The World Health Organization almost fifty years ago challenged the medical definition of health by claiming that health was much more than "the absence of disease or infirmity" and represented a "state of complete physical, mental and social wellbeing." But this statement is so broad that it loses practical meaning. What **is** complete physical, mental and social wellbeing? How do we achieve it? Logically, can we ever really attain it? Without a clear idea of how to act upon this positive notion of health as complete wellbeing, most health professionals and agencies continued to treat or prevent disease.

Many prevention efforts focused on medically-defined or physiological risk factors, such as diabetes, low birth weight in babies, lack of immunization, early cancer detection, high blood pressure or, more recently, high cholesterol or lipids levels. Whether health care was based in doctors' offices, hospitals or public health units, the emphasis remained on treating or preventing disease by correcting problems in the mechanical functions of the body. The term tertiary prevention describes disease treatments which prevent a person from becoming more ill, or from dying; or for programs or actions aimed at physiological risk factors, preventing a serious disease from arising due to less than optimal physical functioning.

The 1970s: Enter the Behavioural Approach

In the early 1970s, health thinking broadened from a medical (physiological) approach to include a behavioural (lifestyle) approach. (Lalonde 1974) There were many reasons for this change in thinking, including the increased role of chronic degenerative diseases (heart diseases, cancers) as leading causes of morbidity and mortality. The infectious nature of HIV is an exception to this transition, although the disease is considered to have multiple co-factors and is a chronic, rather than acute, affliction. Most of these chronic diseases result from the interplay over time of many different factors (determinants), including those that are now referred to as behavioural risk factors. Smoking is one of the most important of these behavioural risk factors, alongside nutrition, exercise, safer sex and others. Any one or cluster of behavioural risk factors are usually associated with several different diseases. There are also many other factors that combine with any specific behaviour to increase disease risks (e.g. asbestos and smoking on lung cancer; high-fat eating, smoking, lack of fitness, family history on heart disease; and so on). Including behavioural alongside physiological risk factors increases the level of complexity at which "health" and "health determinants" are understood.

Health, from the behavioural risk factor perspective, moves slightly beyond disease prevention, and incorporates notions of promoting physical wellbeing (feeling good, having energy, being fit). "Health determinants" become synonymous with "healthy lifestyles." Program actions add educational, marketing and policy theories alongside medical theory. Secondary prevention describes programs or actions aimed at helping people change unhealthy behaviours. Primary prevention describes programs or actions aimed at helping people grow up with, or maintain, healthy behaviours.

The 1980s: Enter the Socioenvironmental Approach

By the early 1980s health thinking expanded again, this time incorporating a sociological and ecological analysis of health and disease. One reason for this shift was the awareness that most lifestyle improvements occurred principally among better educated, more privileged members of society. Healthier lifestyles are often lower priorities for people living in socioenvironmental risk conditions such as poverty, unemployment or low-paying, low-decision latitude jobs. (A low-decision latitude job is one in which the person has little control over the organization and conditions of work.) Moreover, the individualistic nature of health campaigns and education programs tended to "victim-blame" both directly in their content (e.g. "There are no bad foods, only bad eating habits...") and indirectly by their failure to recognize the social and environmental contexts in which personal behaviours are embedded. (Labonte and Penfold 1981)

Another reason for this shift was the awareness that socioenvironmental risk conditions were themselves important health determinants. This awareness followed three professional trends. First, there was frustration with the failure of lifestyle social marketing programs to reach lower socioeconomic groups. Second, many social movements grew and matured during the late 1970s, specifically, feminism, the anti-poverty movement, the environment movement, gay and lesbian rights, the union struggle for safer workplaces, and the peace movement. (Organized actions against "ableism," agism and ethnocultural discriminations are recent additions to this panoply of social movements.) These movements challenged narrow biomedical and individual lifestyle models of health, a point that will be returned to in the next section of this monograph. Third, the activist cohort of the 1960s and 1970s moved into professional jobs, bringing with them more explicitly stated concerns for social justice and environmental sustainability.

The key concept in this expanded vision of health is health promotion. The **Ottawa Charter for Health Promotion** (World Health Organization 1986) defines health promotion as "the process of enabling people to increase control over, and improve, their health." The prerequisites to health are no longer simply disease prevention, or "proper" lifestyles, but include "peace, shelter, education, food, income, a stable ecosystem, social justice and equity." The **Charter** defines five categories of strategies

Table 1: Ottawa Charter for Health Promotion: Strategies and their Problematics

STRATEGY	PROBLEMATICS
Create Supportive Environments	
Ensure physical and social environments support people's abilities to live healthy lives. "Make healthy choices the easy choices."	How do we understand the relationship between environment and economy (sustainable development), and the impact of this relationship on health?[1] How do we avoid "social engineering," the manipulation of external environments for some "right" choice as determined by persons in positions of technocratic power?
Strengthen Community Action	
Support activities that increase the ability of community groups to organize around and act upon those things in their physical and social environments that affect their health.	What is community? Which community groups should be supported? How do we understand power relational issues? Can we avoid the "new behaviourism," the extension of the control professionals and institutions once had over individuals to whole populations and their environments? Is this "community control" or control of communities? (Grace, 1991)
Develop Personal Skills	
Enable people to "learn throughout life" and "prepare themselves for all its stages." Skill areas may encompass personal/familial or group dynamics, organizing, political action, social analysis, etc.	Do health professionals acknowledge the primacy of economic and physical environmental determinants on health, but still see their role as encouraging healthy lifestyle? Is there a residual paternalism: That professionals do "things" (provide information, resources) to "other things" (individuals, groups)? That through this exchange of professional "wisdom" people will become empowered? Does this notion of developing personal skills construct individuals and groups in a passive voice, that is, they are being "done to" and never "doing"?

[1] See Hancock, 1989; Labonte 1991a and 1991b.

Table 1 (cont'd): Ottawa Charter for Health Promotion: Strategies and their Problematics

STRATEGY	PROBLEMATICS
Build Healthy Public Policy	
Most health determinants lie outside medical/illness sector (e.g. income, housing, environmental protection, work, agriculture). These sectors must begin to take conscious accounting of the health impacts of their policies. "Putting health on the agenda of all policy makers."	Does health (however defined) become the superordinate goal ("health imperialism") of all public policy? Is there simply tokenist concern given to health? Can one prevent the biomedical definition of health from dominating health concepts utilized in other policy sectors? How does healthy public policy take account of conflict or social movement struggles?
Reorient Health Services	
Ensure that health care system has health as its output, and not merely the absence of disease. Emphasize services located in, and relevant to, particular needs of localities, i.e., "community-based" rather than "institutional" service delivery organizations. Shift to "health promotion" rather than "service delivery" philosophy.	Does the public understand that expensive high technology treatments have only minimal effect on extending life, or improving the quality of life? What are the opportunity costs of not investing in alternative policy areas such as environment, housing, welfare reform? How do we (health professionals, health agencies) come to grips with, and communicate effectively with the public on, the ethical dilemma of the prevention paradox? This paradox concerns how costly medical procedures often have a direct individual gain (to patients), but have no measurable effect on population health status; while alternative investments in population health strategies (including environment protection, welfare reforms and actions on other socioenvironmental risk conditions) have indirect and low individual gain.

to guide the health sector in this hugely constructed task. While these strategies announce health promotion as a social, rather than only medical or behavioural, practice, each strategy remains replete with problems and in pursuit of greater practice-clarity, some examples of which are provided in Table 1. Much of this monograph is an attempt to work through some of these problems.

Nonetheless, the **Charter** marks an "old" from a "new" health practice, a shift from strictly medical and behavioural health determinants, to health determinants defined in psychological, social, environmental and political terms. Empowerment, or the capacity to define, analyze and act upon problems in one's life and living conditions, joins treatment and prevention as important health professional and health agency goals. Psychological, political and social theories join educational, marketing, policy and medical theories in developing program actions.

While the Charter's definition of health promotion implies political activism, community group mobilization and collective decision-making, there are at least three things we must examine in some detail if we are to make this implication more visible in our work:

1. What is meant by "health" (our criteria for success).
2. What is meant by "increase control over" (empowerment, our role as health professionals in a health promotion practice).
3. What is meant by "the process of enabling" (the role of our health agencies in a health promotion practice).

Each of these is the subject of subsequent chapters. Before turning to them, I will address a rhetorical issue vexing many health promoters and which may provide a unique way to understand the concept: Is health promotion a "social movement?" I will also describe a model and rationale for health promotion as a "Socioenvironmental Approach to Health."

Health promotion, empowerment and social movements

Health promoters often describe health promotion as a social movement. This mimics the manner in which community development was described in the 1960s and 1970s, and how empowerment was described by the mental health literature in the 1980s. Stevenson and Burke (1991), however, argue that health promotion conceptualizers have usurped the discourse of social movements in their emphasis on "the community," and in their lack of focus on the state or macrosocial structures of power. A social movement, whether formalized into an institutionalized lobbying organization or existing as an informal support or consciousness-raising group, exists "out-there" in the associations of civil society. This demarcation between state (government, bureaucracy) and social movement (civil society) is a tenet shared by both major social movement theory streams, resource mobilization theory (e.g. Oberschall 1973, Tilly 1978, Freeman 1983) and new social movement theory (e.g. Eder 1985, Cohen 1985, Melucci 1989).

Health promotion, in contrast, is "a bureaucratic tendency; not a movement against the state, but one within it." (Stevenson and Burke 1992) This is a valuable insight. But does it mean that health promotion surrenders any emancipatory potential to the co-opting power-over tendencies of the state? Is health promotion primarily a clever social marketing ploy to educate civil society groups to the new terms of the state? There is some evidence supporting this bleak appraisal. Grace (1991) points out that health promotion in New Zealand, at least at the senior government level, has been "captured" by a disempowering market discourse in which health becomes a commodity, health promotion a set of market exchanges between consumer (public) and provider (health promoter) for the purpose of reducing disease outcomes, and lessening the need to invest capital in health care, thus freeing up more capital for private accumulative use. Perhaps this is a vestige of social marketing, the immediate health promotion practice precursor to the **Ottawa Charter**. More invidiously, it may represent the colonization of all aspects of life by market concepts as neoliberal economic ideology continues to dominate political life. Most recently in New Zealand (late 1992), former Area Health Boards are becoming "health enterprises," competing to provide services to "patients" who are defined as "customers" and "consumers." One job call, for the Director of Primary and Public Health in one region, described the purpose as "the design, monitoring and refinement of relevant products," using "objectively measured outcomes and outputs" to "initiate new product and service development based on market need." This is the language of widgets and just-in-time factories, not of health and empowerment! In a related matter, Canadian health promotion literature on community mobilization sometimes reads as a manual on how to get community groups to "buy into" the government's agenda (e.g. Health and Welfare, 1992) which often means imposing the language, concepts and cultural norms of bureaucracies on to community groups.

While government initiatives are not **de facto** disempowering, the relationship between state and civil society has disempowering qualities which many theorists relate back to capitalist economies (e.g. Miliband 1973, Offe 1984), and which render the government/community group relationship problematic. Many health promoters seem to acknowledge this problematic by contending that health promotion "belongs to the whole community," thus removing the concept from the troubling power-over tendencies of the state. But this claim denies that health promotion is a term of concern principally to professionals working for the state. Ironically, this claim would fulfill the prophecy of a bureaucratically conceived concept colonizing how people in civil society view their lives: What is important is not your relationships, your work, your identity, your capacity; it is your cholesterol level, and the fact that we have yet "to make healthy choices the easy choices."

There is a way through this impasse that allows us to hold in dynamic tension health promotion's empowering and disempowering potentials. Eyerman and Jamison (1991) discuss social movements as a form of "cognitive praxis." Social movements challenge dominant social beliefs and norms, generate new social knowledge and create new ways of looking at old problems or relations. A struggle for voice and political legitimacy ensues before this new knowledge becomes suffused within society. The women's and environmental movements in their "early" days had to struggle against their dismissal by established power interests as fringe or lunatic; ethnocultural groups today, as part of establishing their legitimacy, are claiming sole right to express concerns particular to their cultural experiences. Vehicles must exist or be created through which new social movement knowledge can be translated into broader social sectors.

The **Ottawa Charter**'s concept of health promotion and community psychology's use of empowerment as an "exemplar of practice" (Rappaport 1987) are such vehicles. Both terms in their elaborated definitions incorporate some of the critiques and new knowledges of the women's, environmental, gay/lesbian rights and other social movements. Both terms imply a social democratic (social justice, moral economy) political ethic. To their advocates, both terms represent several challenges:

* to the narrowness and rigidity of the biomedical paradigm, its declining marginal utility or effectiveness at improving health, the ill consequences of medical or psychiatric labelling
* to the disempowering tendencies of professionals, professionalism as exerting power-over clients or claiming status-driven elitism
* to the disabling qualities of bureaucracies and institutions, their tendency to over-power citizens through their regulations and language.

Health promotion and empowerment exist as lenses through which professional practices can be re-valued. In this re-valuing, neither "the community" (civil society) nor professionals (the state) are privileged as the subjects of emancipatory social change. Rather, emancipatory social change is seen as a product of an empowering **relationship** between professionals and "clients," between institutions and community groups.

The stipulations above do not describe what health promotion or empowerment **are**. Rather, they represent how I and workshop participants found the concepts useful. Conceived as re-valuings of professional practice, health promotion and empowerment exist between two perils: That of coopting or neutralizing social struggle/conflict within the conservatizing ethos of institutions, and that of denying their bureaucratic parentage and naively proclaiming "the community" as the solution to all of our sociopolitical and economic health woes.

Health Promotion and Social Justice

Health agencies confronted with the complexities of inequitable social relationships (disadvantage? oppression? exploitation? intolerance?) often shrug that remediating these problems is the work of social welfare. Yet the health impact of social inequities is striking, and is portrayed in Figure 1. Figure 1 is a useful tool for organizing complex information, and it should not be taken as a statement of truth. The model in Figure 1 was originally prepared for a federal Health and Welfare Canada supported project, **Heart Health Inequalities in Canada** (Labonte and Thompson 1993). It was subsequently revised for the City of Toronto Department of Public Health (1991). The model was built to overcome organizational barriers to a more empowering health promotion practice partly created by epidemiological biases in how organizations "officially" thought about health and health determinants.[1]

Though health status in this figure could be interpreted in either positive (wellbeing) or negative (illness/disease) terms, health research tends to use the latter for historical and categorical simplicity. In the language of social epidemiology, the basic empirical links underpinning this model are:

1. **Risk Conditions:**

   People who experience relative powerlessness as measured by lower socioeconomic status indicators (income, education, occupation) are more likely to experience morbidity and premature mortality; and are more likely to work in dangerous, stressful jobs and to live in polluted neighbourhoods. (Harding 1987; Marmot and McDowall 1986; Wilkins and Adams 1983; World Health Organization 1984; Wilkinson 1986; Gustavesen 1988)

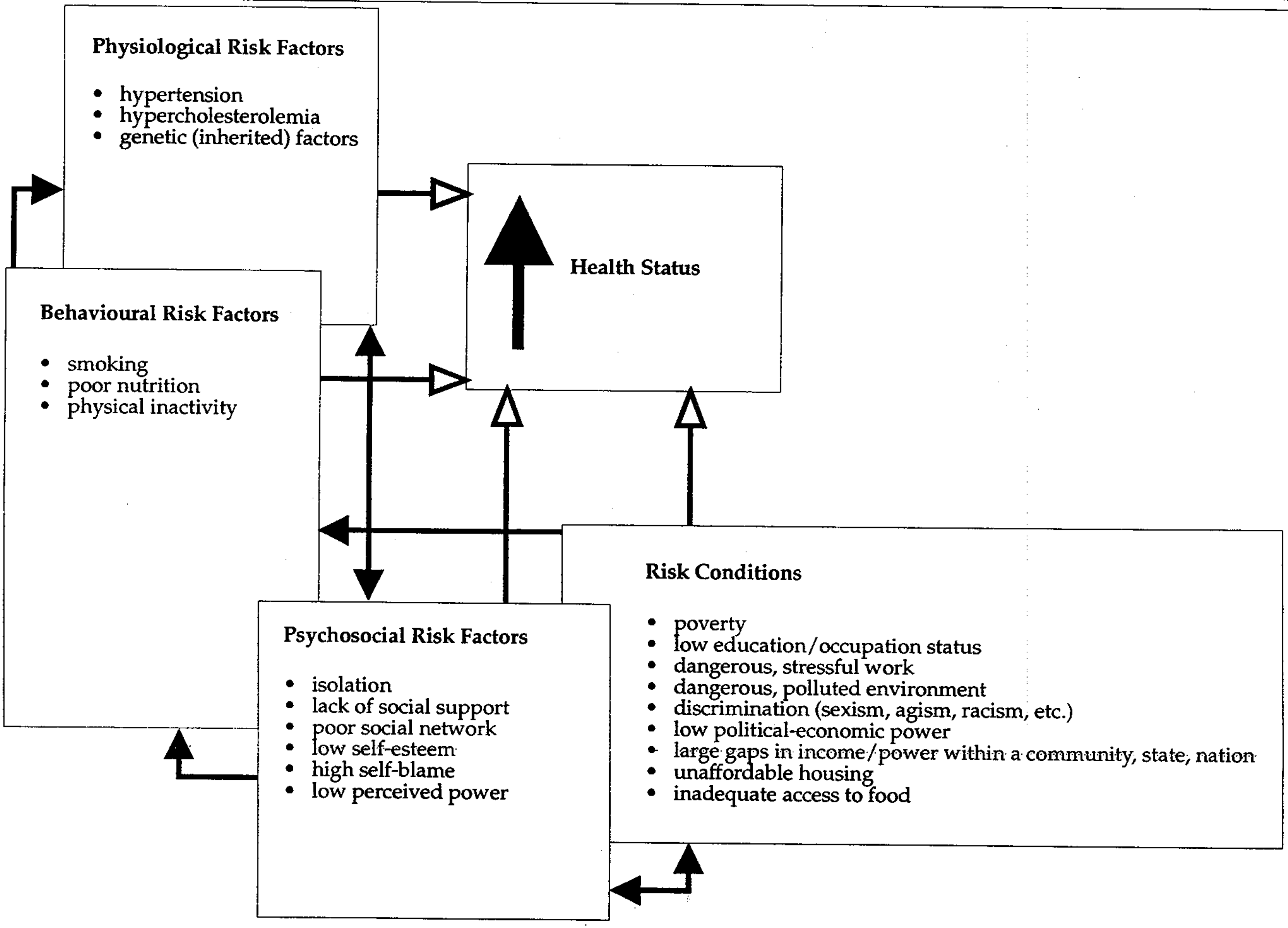
2. **Psychosocial Risk Factors:**

   People living in high risk conditions are more likely to experience less social support and report fewer social networks (Auslander 1988; Berkman 1986), to have low self-esteem, be unhappy and experience self-blame and low perceived power. (Lerner 1986; Harding 1987) This increases physiological functioning associated with increased heart and other diseases, i.e. hypertension, hypercholesterolemia and release of stress hormones. (Berkman 1986; Brindley 1981; House et al 1988) Lack of social support poses a significant independent health risk. The presence of physiological risk factors, diagnosed disease or subjective illness may also compromise a person's ability to maintain social networks and support.

3. **Behavioural Risk Factors:**

   People experiencing these psychosocial risk factors and socioenvironmental risk conditions are more likely to engage in health-damaging behaviours which

Figure 1: The Socioenvironmental Approach to Health



reflects, in part, a "stress-buffering, stress coping" strategy, in the relative absence of social support or social networks. (Hibbard 1988)

4. Because they experience less social support and greater isolation, these people are also less likely to be active in community groups or processes concerned with improving living, working, economic, political or environmental conditions. (Auslander 1988; Minkler 1985a) This reinforces isolation and self-blame, and the "feedback loop" feedbacks upon itself, reinforcing disease/dis-ease.
5. All of the above create and reinforce a more pervasive lack of control, or relative powerlessness, among lower socioeconomic status persons. This lack of control (both real and perceived) may be a fundamental dynamic underlying poverty/illness correlations. (Haan, Kaplan and Kamacho-Dickey 1984; Syme 1986)

Part of the greater morbidity and mortality differences among lower socioeconomic status groups is attributed to a greater prevalence of known individual (physiological and behavioural) risk factors, such as smoking, diet, exercise, elevated blood cholesterol, high blood pressure. (Millar and Wigle 1986; McIntyre 1986) But deaths due to specific diseases and their individual risk factors change over time, while the fact that less powerful groups suffer more disease and live shorter lives has remained constant. (Smith, Bartley and Blane 1990) One compelling example: Smoking rates, today's single leading cause of disease and premature death, were once higher amongst higher socioeconomic status groups, yet lower socioeconomic status groups still had more disease and premature death. Over time, and across nations, the poor appear to be more vulnerable to most diseases, regardless of their specific causes or risk factors. (Evans and Stoddart 1990) One disease inequality tends to be replaced by another.

The gap, or "relativity," of poverty may be a more important health determinant in wealthy countries than the instrumental (purchasing) power of income itself. A study of male British civil servants found that a lower position on a steeply graded hierarchy was associated with increased morbidity and mortality risks, independent of income levels, and exposure to occupational or other environmental hazards. Similarly, amongst the planet's wealthier nations that belong to the Organization for Economic Cooperation and Development, those countries having the greatest after-tax income equality also have the lowest infant mortality rates and longest life expectancies. Rather than the richest, it is the countries where income differentials between rich and poor are smallest which have the highest average life expectancy. In effect, these are the countries where relative deprivation is minimized. (Wilkinson 1986, 1992)

Japan, the reigning monarch of OECD nations, has made substantial health gains over the past two decades and is now the world leader in life expectancy and infant survival. These gains are as great as Britain might achieve if it abolished premature deaths due to heart disease and most cancers. (Marmot and Smith 1989) They are attributed partly to Japan's economic growth, and partly to its relatively equitable income distribution;

Japan ranks fairest in income distribution amongst OECD nations. These gains are also attributed partly to Japan's greater emphasis on "collective" identity, its form of communities/corporate bondedness that may have more in common with the paternalistic feudal village than with North American individualism. (Ornstein and Sobel 1987; Sullivan 1991) Finally, there is speculation that Japan's health gains may represent a "collective" self-esteem; that, as a nation and culture, Japanese share a sense of unsurpassed accomplishment. (Evans and Stoddart 1990; Sullivan 1991) This immediately raises a spectre of ethnocultural elitism and indicates the impossibility or undesireability of prescribing any singular prescription against the powerlessness/ disease relationship. Aggregate (national) studies tease us towards asking better questions about the relationships between social structure and wellbeing, but do not necessarily provide us with the singular dimension or datum upon which we should presume a "healthy" life to rest. However, the point that power equity (a flattened hierarchy of social status) is associated with improved population health indicators still stands.

A nation needs sufficient national income (or at least national resources, income being only a resource-exchanging device in most market economies) to prevent physiologically compromising poverty. But once that is achieved (which is certainly the case in wealthy countries such as Canada), the more basic health/empowerment concern is how equitably that wealth and the decision-making power it provides is shared within the nation. An empowering health promotion practice must include intergroup and interorganizational actions (or intersectoral actions, as the jargon has it) directed towards socioeconomic and political equity. Because injustice creates illness and disease does not render creating justice the singular task of health professionals; but it does require the active participation of health professionals in what might loosely be called social justice movements.

Endnotes

Other models of health determinants are motivated by other intentions. The influential model developed by Evans and Stoddart (1990) was developed to argue for reducing resource allocations to health care, and only begins to make sense when it is assessed through that particular bias.

Chapter 2: Exploring Health

The first major implication of such an empowering health promotion practice lies in how we conceptualize health. While public health has long held to the positive first half of the World Health Organization's famous definition ("a complete state of physical, mental and social wellbeing"), health services, funding and practice remains focused on the second half of the definition ("the absence of disease or infirmity"). Townsend (1990), among many others, argues that this bias is a legacy of the Cartesian mind/body split, with emphasis on the "objective" body representing the core "scientism" of contemporary medical practice. Yet peoples' experiences of health are more about their experiences of capacity and connectedness than about their experiences of disease or disability; or, as Miller defines health, it is "the increased becoming of what we are most deeply." (cited in Hill 1990, p.65)

Table 2: The Experience of Health

energized
being loved, loving
being in control
fit, fitting in, doing
stress-free
outdoors, nature
friends, family
giving/receiving, sharing
belonging
meaning in life
able to do things I enjoy
peak physical shape
happiness
creativity
spiritual contentment
wholeness
playfulness

The few health surveys that have asked open ended questions about peoples' experience of health validate this claim (e.g. Blaxter 1990). Over the years of professional health promotion training workshops, I have often given participants an initiating task of constructing phrases describing a recent time they felt "healthy" and a recent time they experienced "community."

Table 3: The Experience of Community

- commitment
- connectedness
- shared values
- discipline
- action
- sharing, caring
- openness
- belonging
- loved, loving
- respectful
- working hard
- having a purpose
- predictability
- equitable, fair
- fun!

A generic composite of responses is provided in Tables 2 and 3. Table 2, the "experience of health," might be considered the criteria for success in a new health promotion practice. Table 3, the "experience of community," might be considered the criteria for success in a new health promotion process. Few, if any, of these responses concern disease. Moreover, and unlike disease or disability, personal experiences of health are fluid, varying by age and gender, time and place (Blaxter 1990). They are phenomenological experiences, constructed through social interaction with others and our shared repertoire of intersubjective meanings.

We must not despair that health is simply our personal and wholly unique experiences. This plunges us into the cold waters of radical relativism. Radical relativism maintains that the only "true" reality is the unique experience of the individual. (My experience is my truth, my reality, and cannot be questioned, so there.) "Intersubjectivity" is a concept commonly employed in critical social science theory to overcome the limitations of radical relativism. Critical social theorists reject the radical relativists' claim and note that humans are social creatures, whose notion of reality is constructed through the language structures and meanings they share with one another. The "field" of these linguistic structures and meanings is an "intersubjective (between subjects, between persons)" field. Any given person's understanding of the world (her particular construction of reality) is unique to herself, but because it is constructed from a field of more or less common social meanings, communication between people is possible. We never fully experience the meanings another creates of his experience, but the meanings we create of our own experiences overlap sufficiently that we can, with some empathic effort, communicate and otherwise engage in social relations with others.

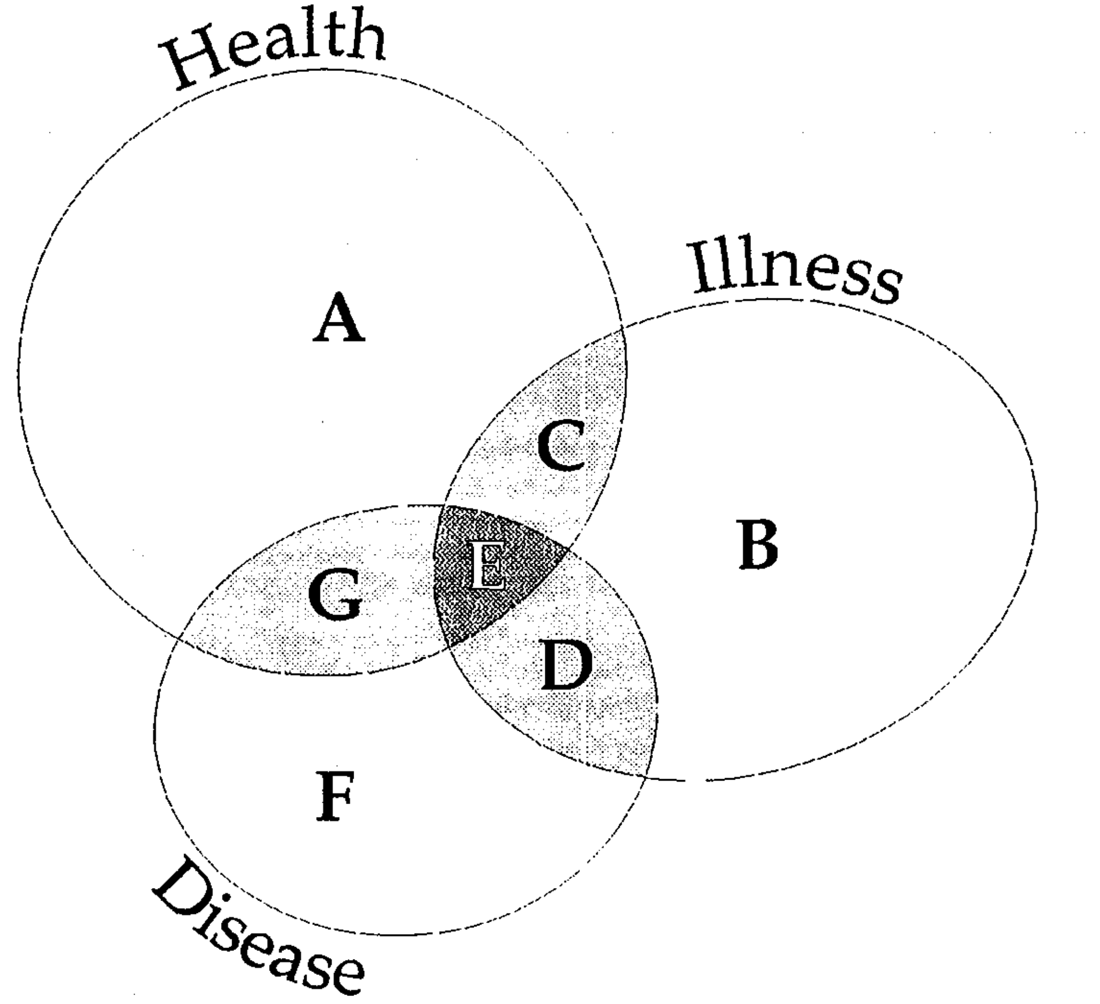
The relational experiences of "being healthy" are not easily rendered into simple, quantifiable measurements. Yet our health care systems persist in defining health in terms of disease or behaviours, the reality of "things" rather than the reality of "experiences." McKinlay (1990), delightfully refers to this tendency as "terminal hardening of the categories," in which the questions we ask about things – usually through surveys, morbidity and mortality reports, or other categorical instruments – tell us what we want to hear by preventing us from hearing what others might be saying. Even Townsend, despite his rejection of the strictly medical paradigm, accepts a reliance on morbidity and mortality data and urges development of quantifiable indicators of wellbeing, an epistemological oxymoron or, more simply said, a self-contradiction. (He is far from alone in this quest for such wellbeing indicators.)

We should not expect to understand health (wellbeing, quality of life) through the same inquiry methodology by which we understand disease. Our experiences of health or illness are discontinuous with disease. Health/illness (a field of self-aware evaluations) and disease (a field of physico-chemical events) certainly interpenetrate. The more positively or optimistically we regard our capacity to cope with or vanquish disease, the greater the chance that we will. But health/illness and disease do not collapse into each other. An attempt to model these non-reducing interrelationships is presented in Figure 2. The modeling in this Figure specifically **rejects** continuum presentations of health and disease, because such continua force a collapsing of health and disease into the same category; they are merely opposite ends of the same "thing," the implicit event that is portrayed by the continuum. Disease becomes "non-health" and health becomes "non-disease." Since disease can be objectively measured by conventional means, and health cannot, disease comes to dominate the continuum and disease prevention sets the boundaries for health promotion. (For an example of this, see O'Donnell 1986a, 1986b, in which health promotion quickly becomes a matter of attaining patient treatment compliance and sustained client behavioural modification.)

Conceptualizing health/illness and disease as more or less discrete events allows me to posit a gentle heresy within the public health field. Many persons with disease, disability or unhealthy lifestyles experience themselves as being very healthy, just as many persons with terminal diseases describe themselves as healthy despite their deteriorating physical state or impending death. (Blaxter 1990; City of Toronto 1988) These experiences of health are mutable and inherently social or spiritual in quality, such as those listed in Table 2. However we name or interpret them, our personal experiences of health may be better predictors of life expectancy than are objective pathology measures. (Ornstein and Sobel 1987; Hunt 1988) Disease **may** eventually become so physiologically taxing that it inhibits our ability to experience health. Our self-awareness and consciousness, to use Schumacher's terms (1977), may be ontologically discontinous with our physico-chemical "self," but they are not separate from it.

In Figure 2, the shaded area F represents undiagnosed or so-called "silent" pathology, such as hypertension, cardiovascular disease, congenital diseases, cancers. By medical criteria, these persons should be ill, though often feelings of illness only occur later in

Figure 2: Health, Illness and Disease



Legend:

Circle A represents health or wellness, the clear area being experiences such as those listed in Tables 2 and 3.

Circle B represents experiences of illness, the clear area representing illness that cannot be explained by conventional biomedical concepts and research.

Shaded area C is feeling "so, so," when/where it doesn't take much to tip one into wellness or illness.

Shaded area D is where a diagnosed pathology objectively validates and explains the subjective experience of illness.

Shaded area E represents feeling "so, so," being diagnosed with a pathology, and becoming sick.

Circle F represents diagnosed pathology, the clear area being undiagnosed or silent pathlogy, such as hypertension, CVD, congenital diseases, cancers.

Shaded area G represents being diagnosed with a pathology, but still reporting oneself as feeling well or healthy.

the pathological process, or never at all. There is a medical tendency to seek out such persons through screening programs. When this results in early efficacious treatment (e.g. cervical cancer screening) it is personally beneficial and potentially empowering. When there are few or no efficacious treatment options (e.g. borderline cholesterol or hypertension screening), it is of questionable beneficence and has the disempowering effect of labeling people as sick or behaviourally bad.

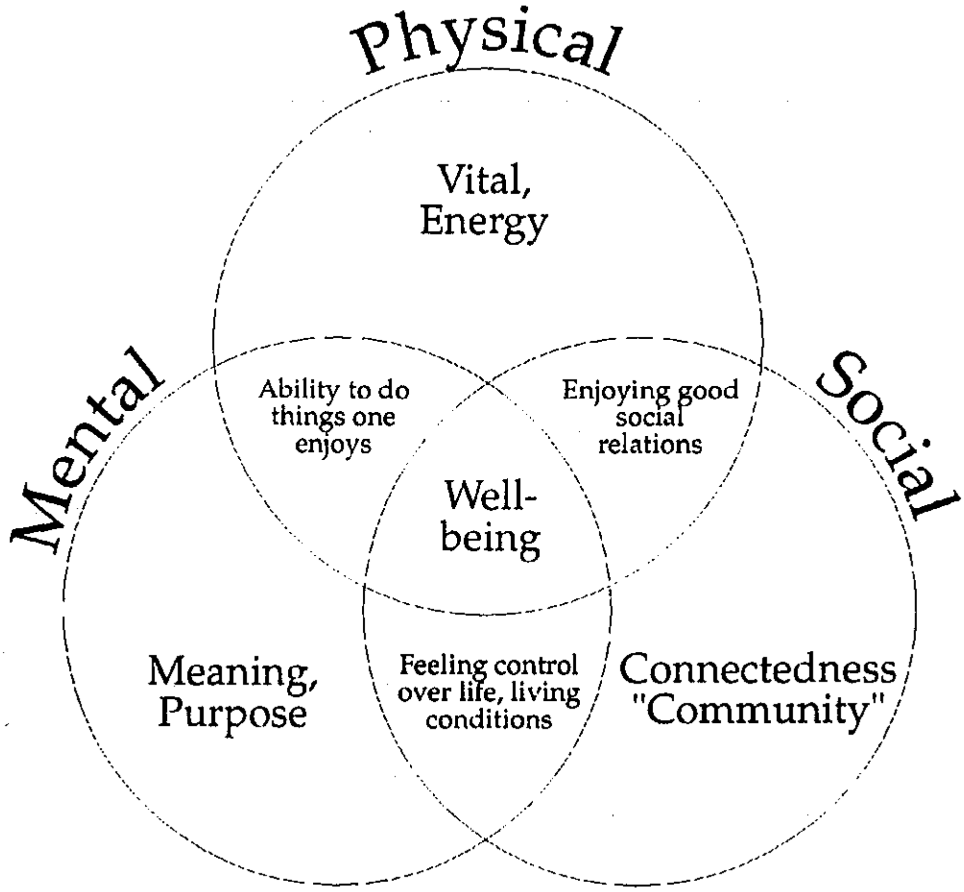
The overlap of disease and health (shaded area G in Figure 2) represents the conventional paradigm's true blindspot. That health and disease are discontinuous, and that health and disease may be experienced as relatively separate phenemona, allows the possibility that a personally empowering health promotion program, built upon good social theory (e.g. small group theory, critical pedagogy, community development, empowerment theory), can improve health (wellbeing) without necessarily reducing the prevalence or risk of disease, or of specific disease risk-factors such as smoking, high fat intake or lack of fitness.

This is not a profound insight; it is commonsensical and well if tacitly accepted by most health promoters. It also forms the explicit interest area of much health psychology. Yet it remains one of the more vexing issues within health promotion practice today. Its vexatiousness reflects a collective failure within the field to recognize **health** promotion as something both larger than and distinct from **disease** prevention, with differing paradigmatic considerations. Adorno (1957) years ago made the point that neat, categorical means of organizing knowledge (the methodological hallmarks of the disease prevention paradigm) fit the disempowering administrative agenda of bureaucratic institutions. The extent to which the **dominance** of the disease prevention paradigm is successfully challenged within health organizations (and not necessarily the paradigm itself, which does provide useful and important information) may mark the extent to which the organization frees itself from its power-over tendencies to manage, predict and function as maintainers of a social **status quo**. It is certainly requisite to any professional or institutional practice that calls itself "empowering."

(The medical/disease prevention paradigm is sometimes referred to as the **conventional** paradigm, and is distinguished from the **contructivist** and **critical** paradigms. The conventional paradigm assumes the nature of reality can be objectively determined. The constructivist paradigm considers reality to be a socially constructed phenomenon rather than an external absolute. The critical paradigm adds that these social constructions of reality contain implicit power relational statements to which we must pay careful heed. These paradigms are described in greater detail in Chapter 3.)

The subjective nature of health as wellbeing does not mean that health loses all precision in meaning. It does free health from any necessary relationship to disease, but it does not render the field of health a relativist jungle of individual experiences in chaotic abandon. All inquiry, regardless of methodology, creates some form of categorization

Figure 3: Dimensions of Health and Wellbeing



or order to data, otherwise it would be impossible to talk with one another about the significance of the data. It is possible to organize peoples' particular experiences of health into more generally stated descriptive categories. One such effort identified the following categories:

1. feeling vital, full of energy
2. having good social relationships
3. experiencing a sense of control over one's life and one's living conditions
4. being able to do things one enjoys
5. having a sense of purpose in life
6. experiencing a connectedness to "community"

(Adapted from Blaxter, 1990; Registered Nurses Association of British Columbia, 1990) Figure 3 sets these six categories against the WHO notion of physical, mental and social wellbeing. The coherency in this model is that:

- We need a degree of physical vitality **and** a certain connectedness to others (groups, community) to enjoy good social relationships.
- We need a degree of physical vitality **and** a sense of meaning and purpose to both know, and act upon, what we enjoy.
- We need a sense of meaning and purpose **and** a certain connectedness to others (groups, community) to experience a sense of control over our lives and living conditions.

This modeling of positive health could allow us to plan our health care systems, health promotion programs and community-based health services quite differently than we do at present, yet with some order and logic. The six spheres serve as guideposts to the types of experiences we would seek to measure (inquire into) if we were interested in health, rather than the absence of disease, as an outcome.

Different cultures use different modeling techniques. As one salient example, many non-European peoples (particularly the indigenous populations of the Americas and the South Pacific) construct health as a four-sided phenomenon, embracing the physical, emotional, mental and spiritual dimensions of the self. A contemporary vision of Amerindian health, from the perspective of an inland Salish (West Coast tribe), Lee Brown, is one of:

> ...moving toward the unique gift the Creator has hidden within each one of us. (This movement) produces four inter-related conditions:
>
> 1. a sense of purpose
> 2. a sense of the meaning of life
> 3. a sense of direction
> 4. a sense of connectedness with all things
>
> (Brown 1990)

Although this model is different than the one in Figure 3, and specific measures developed from it may vary, the ethos is the same. One must be cautious to avoid generalizations about positive health, and certainly about generalizing **measures** of positive health, that cross histories and cultures. At the same time, there are sufficient commonalities across time and peoples that some alternate models, outcomes and success criteria to disease and disease prevention might reasonably be suggested.

Health and Social Support

The relational dimension of our experiences of health and community is supported etymologically and empirically. Etymologically, the English word "health" shares the same root as "whole" and "hello." In many other languages, the word for greeting is the same as the word for health. Our folk wisdom appears to hold health so central an experience that wishing it upon others is the first basis of our social communication. Our folk wisdom also reflects the inherent sociality of this experience, that without caring, respectful relationships with others our experience of health withers and our risk of morbidity and mortality increases. Researchers in recent years have studied this relational phenomenon of health, using the construct of social support. Social support refers both to one's social networks (family, friends, groups, organizations, and so on) and the emotional, material and companionship support they offer. Based on years of his own, and other's research, House argues that "...social relationships and networks supports are the most powerful and reliable predictors of physical and mental health..." (House 1986) Social support enhances health through both a direct or main effect (people are healthier because they have social support) and a stress-buffering effect (social support reduces the physiological stress reaction to social stressors). (Cohen and Syme 1985) Social networks predict health as far as a direct or main effect is concerned; people who have familial, interpersonal and community networks have less disease than those who do not. But in instances of acute or cumulative chronic stress, the quality of support becomes more important than the quantity or potential of support.

Whatever this phenomenon is (one researcher referred to social support simply as "the gluey stuff, without which our communities and our health fall apart") it is a powerful factor in our experiences of health, both as wellbeing, and as freedom from disease. Although not all the biological pathways through which isolation or lack of social support lead to disease are known, it likely functions through altering physiological risk factors such as blood pressure, serum lipids, immune system functioning and stress hormones. (Brindley 1981; House etal 1988, Pelletier 1992) Human and animal research on psychoneuroimmunology supports these findings; in particular, some confluence of perceived control over external stressors, feeling loved and supported, and experiencing a commitment to some purpose may be important predictors of life expectancy. (Pelletier 1992)

The construct of social support, while important, remains problematic for several reasons. First, researchers sometime attempt to reduce and quantify a complex set of human interactions and experiences. This type of scientific reductionism reaches absurd levels in efforts to determine precisely how many contacts, with which friends or family, under what circumstances, and with what particular types of behavioural exchanges, may maximally improve our health. Second, the construct embeds within this reduction and quantification the harder-to-itemize "quality" of the actual relationship, the "support" that characterizes the caring between persons. Third, there are significant gender and geographic differences, e.g. the health difference of support vs. no-support is greater for men than for women, and greater in urban than in rural settings. This may reflect, on the one hand, gender differences in the perceived importance of, and literacy in, intimacy; and, on the other hand, that in rural settings you're more likely to be completely "in" or completely "out," and so there would be little gradation in health and social support indices. Fourth, many of the measures are middle-class biased, e.g. an indicator of social support is having a friend who could drive you to the hospital in the middle of the night. What if your friend did not have a car, but could arrange a taxi, or an ambulance, or go with you by bus?

Yet even as a muddied construct, social support conveys the importance of social relationships to health, representing a sort of paradigm bridge between those who would see health as the dance of atoms in the human genome and those would see health as the human dance in a swirl of social atoms. In a strictly Kuhnian sense, of course, social support might be regarded as the successful effort by the paradigm of atoms to explain the dance of humans, and so preclude a crisis in legitimacy in the dominant paradigm. (Kuhn 1970) We will encounter later a more reactionary interpretation of social support on a similar charge: That of deflecting a political crisis in the legitimacy of the state. But I would still urge a certain faith in the resilience of the human spirit to marvel at the "gluey stuff" even as it engages in multivariate regression analyses.

The Maori of Aotearoa ("land of the long, white cloud," the Maori name for New Zealand), in their four-sided vision of health, offer another understanding of the inherent sociality of our experiences of wellbeing. Health is thought to comprise the positive expression of:

te taha wairua (the spirit)

te taha hinengaro (the mind)

te taha tinena (the body)

te taha whanau (the family, the community)

This last conceptualization is particularly interesting, locating within the territory of health an awareness of one's ancestors and of one's belonging to an extended family. This social dimension to health recurs in other cultures. The Samoans, distantly related to the Maori, strongly believe that neither health nor illness are matters of the individual, but are inextricably linked to the family and community. When one individual falls ill, the whole family must be treated. As in many non-European cultures, the pursuit of individual health (wellness, lifestyles) to Maori and Samoans may actually be perceived as a pathology because it fails to locate the experience of health within sociable, community relationships.

Let us consider now the practice implications of the fact that good social relations are important predictors of good health. Apart from the simple and arguably simplistic task of socially marketing friendships as health-promoting (see Gottlieb 1987), health professionals might always ask of themselves and their agencies: How can whatever it is we are attempting to do lead to better social networks, improved social support, greater group actions on socioenvironmental risk conditions?

For example: It is well known that isolation amongst young mothers, rural women and widows increases the risk of mental and physical disease and illness. When breast or cervical screening programs are offered to these women, they could include (at a fractional increase in costs) community health workers whose task it would be to support and resource any women interested in starting "self-help/self-health" groups on whatever issues that may be of interest to the women. Not all women would choose to participate in a group, but some would and the importance of small group development as a health promotion strategy lies in making the offer. Such groups may actually do more to extend a healthy life than the benefits of the screening program itself!

This type of institutional support provides a resource or "mobilizing space" in which the broader health interests of the women's movement might be expressed. The screening program decision-makers, of course, must first see the value of a women's health movement. They must allow themselves to be "coopted" by these values, the commonwealth of values articulated by women's groups as part of feminism as a social movement and creator of new social knowledge, rather than coopting women health activists to their own institutional values. Usually the reverse is true, and women health activists attempting joint partnerships with health authorities may experience a subtle shift from social movement challenge to institutional cooptation along the axis of administration.

A women's health group in New Zealand/Aotearoa, for example, negotiated to undertake a portion of cervical screening for a regional health authority. While the women's group was interested in preventing unnecessary cancer deaths in women, its agenda was much broader: Empowerment, psychosocial wellbeing, peer support and a more politicized and feminist form of health education. The terms of their contract, however, progressively consumed more of their volunteer time in program management and accounting, and progressively defined their successes in narrow terms of physico-chemical data (cervical screening and cancer rates). While not fully coopted by the institution, this group arguably had been coopted to a greater extent to institutional paradigmatic values than vice versa.

Another example illustrates the paradigmatic "drama" in our practice use of social support and subjective evaluations of wellbeing. The paradigmatic drama takes the form of a role-play that spontaneously erupted in one notably entertaining workshop.

The issue involves a women's "self-health" program nominally organized to improve health behaviours (smoking, nutrition) of low income women, most of whom were single parents.

MANAGER: I see you're applying for more funds to run the program a second time. Why? Be brief, I've only a few minutes.

WORKER: Well, the program proved successful beyond our expectations. We think it is very good for the women who participate.

MANAGER: Oh? How so? According to your service stats only 1 of the 18 women in the first group quit smoking, you've got no data on the maintenance of that change, and there was only a marginal shift towards better nutrition in the pre- and post-test 24 hour food recall scores. Doesn't seem like a success to me.

WORKER: But we know that the women reported feeling much better about themselves as a result of the group. Most of them were quite isolated before coming to the program. Now they've formed their own support group.

MANAGER: So you're asking me to spend another $7,000 in program funds just because the participants felt better? Look, I've surgery queues and immunization problems and we need a new intensive neonatal unit at the hospital. Every penny has to count and we're not in the business of making people feel better about themselves. We're here to prevent or treat disease.

WORKER: Wait. I don't think you understand...

MANAGER: I think it's you who don't understand! How are we going to set priorities if we don't have hard outcomes?

etc. etc.

At this point the role-play went in several directions. In one instance the worker chose to replay it and simply lied at the outset, inventing the statistics the manager wanted to hear. This may have secured her more program funds, but it put her own professional future in jeopardy and did not contribute to shifting the organization's understanding of health, empowerment and constructivist (qualitative) research/evaluation approaches. In another instance, the worker engaged in heated argument, trying to make his manager wrong by pointing out that the program cost for even one smoking cessation was less than 10% the cost of a coronary by-pass operation. This only raised the hackles of the manager who specialized in cost-efficiency studies and insisted upon knowing the worker's sources for that comparison. The worker had none. In another instance, the worker argued polemically that, surely, making people feel better was exactly what a health agency was about. The manager stated that if that was how she felt, she should apply for the next opening in the social welfare department.

As participants in the workshop in which this role-play emerged tried different approaches, the one that seemed most effective was when the worker engaged in an educational exchange with her manager, sticking to her position but using solid argument expressed in the language and paradigmatic values her manager would understand.

WORKER: Yes, I appreciate the difficulty you're having with the funding decisions. But this program does improve health and, if we accept that improved health is less expensive that sickness, it fits the quality assurance criteria for efficacy. Here's a report on how the women described their own experience of their health when they first entered the group. The names have been blacked out, but they told me I could share their observations with you. (Manager glances at comments.) And now here is how they talk about their health after the program. Look at the difference! (Manager glances at second set of comments.)

MANAGER: Sure, that's fine. But how valid is this stuff?

WORKER: The women's journals, as agreed by them, were analyzed using a grounded evaluation method.

MANAGER: What?

WORKER: It's a standard qualitative research method. I've got the evaluator's report, if you want it, but I thought the women's own words are a more powerful record of their change process.

MANAGER: OK. And I do appreciate the work you've done, and the experiences these women have had. But where's the behaviour change? Where's the bottom line?

WORKER: I don't want to sound cheeky, but I have to ask you: Do you know of any theory or research to support why you think a group of poor, isolated single mothers coming together for the first time should be initially and primarily concerned about their smoking behaviours?

MANAGER: What do you mean?

WORKER: What I mean is that there is good theory and considerable research indicating that the greatest health improvement these women might experience is simply their involvement with each other. Here, look at these findings. (Hands him a synopsis of research studies on social support and health.) There's also a subset of this research that indicates that providing service to others – which is certainly how these women now talk about their relationships with each other as a result of the group – is a good predictor of overall lifespan.

MANAGER: Fine, fine. But you and I both know that what we're interested in, what this agency is funded for, is health education. The whole reason the group ran in the first place was to reduce risk factors for heart disease. So where's the reduction?

WORKER: (patiently, but not patronizingly) Please read these reports. I've highlighted the important sections. What they indicate is that health behaviour change may be less important an outcome – and certainly less achievable an outcome – than these other things I've been talking about. And, at the same time, health behaviour change **may** be influenced by the very things the group I ran talked about and led to.

MANAGER: I don't follow.

WORKER: Well, the group we ran made these women feel a lot better about themselves – and these women **knew** that they had changed, and helped us to document these changes. But it also seems that this kind of experience and the kinds of changes these women had – feeling more capable, more powerful, feeling a greater sense of belonging – these experiences may be more important to their physical health than whether or not they quit smoking, change their diets, lose weight, you name it.

MANAGER: So this group thing is actually **good** at preventing disease?

WORKER: It would seem so, though explaining how or why isn't as straightforward as explaining the link between tobacco use and cancer, and probably never will be.

MANAGER: But what about the lifestyle stuff?

WORKER: That's another reason why we want to run more of these groups. And why we want to keep in touch with the women in the first group. Here. (Hands him another brief report.) This is an anecdotal survey I did of other health workers who've run similar groups with similar women in the country. It seems that many of these women who come to these groups – regardless of the group topics, it could be rent control issues, parenting problems, welfare hassles, or basic health education stuff on body care, breast self-exams, whatever it is that seems important to these women at the time – anyway, it seems that after a while participants start to get interested in lifestyle behaviours on their own. Somehow the group participation process, or breaking down some of their isolating barriers, or perhaps even seeing the willingness of people in agency's like ours to provide information and help on topics the women themselves think are important; these things somehow create a motivating interest in health behaviours. But it takes awhile and it's not always certain. There's some research, for example, that finds that for many women like those in our group, smoking is the one thing they feel they can control in their lives, so that smoking has a significance in terms of personal power far different from, and more important than, our view on smoking in physical health terms. But if they find **other** ways to experience control or power, do they then turn more attention to smoking? We want to look at this process more carefully. I've already been in touch with some of the community psychology people at the University, who are interested in helping us to study these group and personal change processes.

MANAGER: Community psychology? Don't you mean the epidemiology and behavioural science department?

WORKER: No. Because what we're talking about here isn't disease anymore. It seems to relate to disease, but it's different. And I want to emphasize that we shouldn't **expect** these groups to lead to health behaviour change, to have that as our hidden agenda. The group participants' literally negotiate their own learning goals with us and, from the literature I've provided, this negotiation and the group experience – properly facilitated – can give us enough positive health without looking for other success criteria. Ultimately, what we're talking about here is how people relate in groups and how, through the experiences they gain in these groups, they change in their relationships with themselves, their families and friends, and larger institutions and political systems. You know an epidemiologist trained to evaluate that sort of thing?

MANAGER: Well, no. But what's this got to do with disease prevention? We've got to remember our mandate. We can't be everything to everybody, you know. Why couldn't welfare run these groups instead?

WORKER: First, welfare could run these groups, but they're not, so we are; and even if they were running these groups, there'd still be a need for us to do them because, after all, we're recruiting women to these groups through the hospitals and clinics, aren't we? Second, the middle report I gave, the one on social support and environmental and social health determinants, that one lays it all out. Isolation, lack of support, feelings of powerlessness – these are very real causes of very real diseases! And they're far more important causes than we previously thought.

MANAGER: OK, OK. But why do you insist on using funds from the smoking and cardiovacular disease prevention budget? Seems to me those things are only of secondary importance to your group work.

WORKER: They are only of secondary importance. But do you have a program budget called "empowerment?" (pause) I didn't think so. So until you do, I need the funds from wherever I can get them.....

This role-play presents a rather idealized ending; not all managers or organizations are as tractable when presented with good argument or discussion. Also, this role-play chooses what is probably a more "real-life" middle course of attempting to explain the intent of the group using the language of both the conventional and constructivist paradigms. Yvonna Lincoln, one of the main proponents of the constructivist paradigm, argues that "accomodation between and among paradigms on axiomatic grounds is simply not possible." (1990, p.81) This may be true in theory, but hardly so in practice. Perhaps, as one frustrated health promoter confronting these debates decried, "Paradigms are what researchers invoke when they don't have two nickels to rub together!"

Hearing the manager's concern (limited resources, competing demands, objective decision-making models) also allowed the worker to frame her request in those terms. This was not simply good strategy; it also conveyed respect to her manager and organization. People may not be able to hear or to learn things which are novel to their previous ways of looking at themselves and the world, or which are stated in a completely novel fashion. (This is one of Kuhn's (1970) premises respecting paradigms, what colloquially has become called "paradigm blindness" or "paradigm paralysis" best evidenced in the idea of the fish being the last to discover water. We do not see the assumptions in which we are immersed, until somebody less wet behind the ears asks us, "Oh?") This seems to be well understood in community organizing work, where one always strives to "start where people are." But we don't often apply this axiom of practice to our own organizations. To start where our health organizations are is to strive to explain the social phenomena of health we come to "know" through a constructivist paradigm of inquiry, in the language of "proof" that our organizations and their conventional paradigm understand. This is not a placatory act, so much as a communicative act.

Naming Health Problems

The act of naming one's experiences as they have been lived is essential to an experience of self-efficacy or empowerment. This does not mean that how one interprets one's experiences is true, or necessarily empowering; as Fay (1987) cautions, there is still the problem of false consciousness, of viewing one's life through the internalized and distorting conceptual lenses of those who hold power over one. The power of the word draws attention to the professional need to respect how people identify their own concerns and issues. If we fail to "start where people are," if we seek to impose our health problem concerns over theirs, we risk several disabling effects:

1. We may be irrelevant to the lives and conditions of many persons.
2. We may further their experience of powerlessness by failing to listen to, hear and act upon concerns in their lives as they experience and name them, communicating to them that they are wrong and that we are right.
3. We may further complicate and overwhelm their lives by continuing to insert into them more and more "urgent" problems that they must address and "buy into."

In an earlier work based upon the workshop sets (Labonte 1989a) I suggested that there are three broad clusterings of named health problems. (Table 4) These clusterings were created through a sorting process for answers to the generic question, "What are the leading health problems facing your community?" Each of these named problems embeds a set of assumptions, detailed in Table 5. The three approaches described in Table 5 are ideal types; they are not fully self-contained practices. The boundaries between these approaches are fuzzy, and health professionals may find themselves alternating between them at different times and for different purposes. All of these approaches are important and useful. It is the dominance of, first, the medical and, more recently, the behavioural that has pushed the socioenvironmental into current attention.

These three approaches also represent **organizational biases**, i.e. hospitals tend to work from a medical approach, state agencies from a behavioural approach, and community workers from a socioenvironmental approach. These biases condition and constrain the ability of workers employed within these organizations to act effectively or legitimately within a different approach. They may lead to a situation in which the professional is unable to enter a dialogue with her community groups in search of some shared meaning, some problem-naming that respects how persons experience their lives. Instead, she persists in actions that seek to educate these groups to the terms of the health agency.

A good example of this problematic comes from a PATCH, or Planned Action Towards Community Health, program in the United States. A community opinion survey found that violence and drugs were major concerns. The behavioural risk factor survey

Table 4: Leading Health Problems by Three Approaches

MEDICAL APPROACH	BEHAVIOURAL APPROACH	SOCIO-ENVIRONMENTAL APPROACH
CVD	smoking	poverty
cancer	poor eating habits	unemployment
AIDS	lack of fitness	powerlessness
diabetes	drug abuse	isolation
obesity	alcohol abuse	pollution
mental disease	poor stress coping	"stress"
hypertension	lack of lifeskills	hazardous living and working conditions
etc.	etc.	etc.

identified heart disease. The community opinions were put on the back burner. Screening tests, lifestyle counselling and referrals were offered, because those were the categories of the professionals to which the community must be educated. (Bogan III etal 1992) Some Canadian PATCH programs have dropped the risk factor survey altogether (it is normally part of the PATCH protocol), believing that a commitment to reducing health inequalities must proceed with the knowledge that the most important act of power is naming one's experience, and having that naming heard and legitimized by others.

Another example exists in a survey of public health professionals in Ontario, conducted around the time of the Adelaide WHO Conference on Healthy Public Policy. (Labonte 1988/89) Respondents (N=180, 22.5% response rate) claimed that leading health problems were poverty, unemployment, social inequalities generally, and environmental pollution/toxification. At the same time, respondents indicated that priorities for their **own** professional work and institutions were smoking, nutrition, fitness and other lifestyle, behavioural issues. There is an awareness of broader socioenvironmental health issues; indeed, it has even been reified in the notion of "determinants of health."[1] Examining what this "new" knowledge challenges in professional and institutional practice lags behind.

Table 5:
Different Approaches to Health Enhancement

	MEDICAL APPROACH	BEHAVIOURAL APPROACH	SOCIOENVIRONMENTAL APPROACH
health concept	biomedical, absence of disease, disability	individualized, health as "energy," physical-functional ability, physical "wellness," appropriate disease-preventing lifestyles	positive state that is largely defined in connectedness to one's family/friends/community, self-efficacy, "being in control," ability to do things that are important or have meaning, psychological and social "wellness"
problem definition	disease categories and physiological risk factors physiological risk factors: hypertension, hypercholesterolaemia, genetic predispositions, other physiological "deviations" from a norm, or presence of epidemiologically established risk factors	behavioural risk factors: smoking, poor nutrition, lack of exercise, unsafe sex, substance abuse, etc.	psychosocial risk factors and socioenvironmental risk conditions psychosocial risk factors: isolation, lack of social support, poor social networks, low self-esteem, self-blame, low perceived power socioenvironmental risk conditions: socioenvironmental situations which may support unhealthy lifestyles and which also increase susceptability to ill health, e.g. poverty, low education/occupational status, dangerous/stressful work or physical environments, discrimination, relative political-economic powerlessness, large gaps in community-social distribution of income-power

Table 5 (cont'd):
Different Approaches to Health Enhancement

	MEDICAL APPROACH	BEHAVIOURAL APPROACH	SOCIOENVIRONMENTAL APPROACH
principle strategies	surgical intervention drug and other therapies health care (illness-care) medically mananged health behaviour change (diet, exercise, patient education, patient compliance) screening for physiological risk factors	health education social marketing health advocacy for healthy public policies supporting lifestyle choices (e.g. workplace smoking bans, low fat meat production)	personal care (supportive mentors, crisis workers, direct service providers) small group development (health education/social support, strong group/self identity) community organization (community development, strengthening community actions on health determinants, social marketing) coalition building and advocacy (development of and advocacy for healthy public policies) political action (creation of shared future visions, participation in/support for social movements
target	high risk individuals	high risk groups (those with unhealthy lifestyles) children (promotion of healthy lifestyles)	high risk conditions
prevention level	tertiary prevention disease intervention	secondary prevention (improving lifestyles) primary prevention (creating healthy lifestyles)	primary prevention (creating healthy lifestyles) health promotion (creating healthy living conditions)

Table 5 (cont'd): Different Approaches to Health Enhancement

	MEDICAL APPROACH	BEHAVIOURAL APPROACH	SOCIOENVIRONMENTAL APPROACH
program development	professionally managed	negotiated with individuals, communities and professionals, that is, community-based programming commmunity-based programming: the process of health professionals +/or health agencies defining the health problem, developing strategies to remedy the problem, involving local community members and groups to assist in solving the problem, working to transfer major responsibility for on-going program to local community members and groups	managed by community groups in critical dialogue with supporting professionals and agencies, i.e. community development programming community development programming: the process of supporting community groups in their identification of important concerns and issues, and in their ability to plan and implement strategies to mitigate their concerns and resolve their issues.
success criteria (examples)	decrease in diagnosed morbidity decrease in specific age-standardized mortalities decrease in prevalence of physiologically defined risk factors	improved existing lifestlyes (behaviour change) healthier lifestyles "early in the life-cycle" enactments of healthy public policies related to health behaviours (e.g. smoking bans, food marketing practices, restaurant policies, etc.)	improved personal perception of health improved social networks, quality of social support improved community group actions to create more equitable social distribution of power/resources improved community group actions to create more environmentally sustainable personal, public and private economic practices shifts in social equity measures in the direction of greater equity shifts in sustainability measures in the direction of reduced ecosystem stresses

Community-Based, Community Development Programming

Allowing individuals and groups to name their own health concerns or issues (which may be quite different from how health agencies or professionals view health problems) is one of the most important axioms of an empowering health promotion practice. Most health agencies work from a community-based rather than community development perspective, but subsume both types under the single moniker of community development, thus burying the importance of how, and by whom, health problems are named. (Table 6) They make invisible the power differences that characterize community group/institutional relations.

Community-based and community development programming differ not only in problem-naming, but in how program planning is approached.[2] In workshops, I often heard the claim that "you can't really plan community development, it just happens and you go with the flow." Yet I also heard that, among other things, an empowered person has increased his ability to reflect more critically on his situation. This implies some planning, deliberation and rationale for choosing certain actions over others. To say that community development is not planned is to say that one is using unconscious, and hence uncritical, planning assumptions. While errors may be the essence of learning, the greater power of professionals in their client/community group relations carries with it a greater responsibility to surface their assumptions and to minimize what may be hurtful, avoidable mistakes.

Community development planning is not the same as that typically used by large, bureaucratic organizations. (Figure 4) It is the alieness or inapplicability of this approach to community development, in particular the requirement that goals be specified before any actions commence with little accomodation for feedback loops and changes in goal or objective statements, that leads many health workers to proclaim that community development "cannot be planned."[3] A community development approach to program planning is different (Figure 5) in at least three respects:

1. It is deliberately iterative, because it is premised on ongoing negotiations between organizations and groups, via the community development (health promotion) worker.

2. As such, objectives and goals emerge through the process and are subject to constant revision. In the conventional approach, these emergent learnings are sometimes referred to as the program's "unintended outcomes," those interesting deviations from the original plan. In the community development approach, these deviations are not unintended; they **are** the plan.

Table 6:
Community-Based and Community Development Programming

COMMUNITY-BASED PROGRAMMING	COMMUNITY DEVELOPMENT PROGRAMMING
The process of health professionals and/or health agencies defining the health problem, developing strategies to remedy the problem, involving local community members and groups to assist in solving the problem, working to transfer major responsibility for on-going program to local community members and groups.	The process of supporting community groups in their identification of important concerns and issues, and in their ability to plan and implement strategies to mitigate their concerns and resolve their issues.
Example: Almost any health education or prenatal program, or multiple risk factor reduction program.	Example: Healthy Communities projects.
Characteristics:	Characteristics:
• There are defined program time-lines.	• The work is often longer term, and without defined time-limits.
• Changes in specific behaviours or problems are the desired outcome.	• A general increase in the group's capacities to act effectively in its social world is the desired outcome.
• Decision-making power rests principally in the institution.	• Power relations are constantly negotiated.
• The problem name is given.	• The problem name starts with that of the community group, then is negotiated strategically, i.e. to a problem-naming that most advances the shared interests of the group and institution.

Figure 4: Community-Based Planning Model

goals

↓

objectives (only one measurable outcome per)

↓

rationale (in disease prevention terms)

↓

activities (tied to specific objectives)

↓

outcomes (tied to measurable units based on objectives)

↓

indicators ("validated" instruments)

Figure 5: Community Development Planning Model

intentions (reflections: why are we professionally interested? our claims/concerns/issues)

↓

meetings with groups (interactions: what are groups interested in and why? negotiations over shared interests)

↓

draft goals (visions: our moral notions of right and wrong)

↓

actions based on negotiations (objectives: what we specifically hope to achieve in the first round)

↓

qualitative forms of documentation (thick description, diaries, participant/observation notes, etc.)

↓

refinement of first or development of new objectives based on "learning" from actions

↓

quantitative forms of documentation (as more specific objectives emerge from practice, and to degree changes can be quantified)

↓

final goals (which emerge near the end of the process)

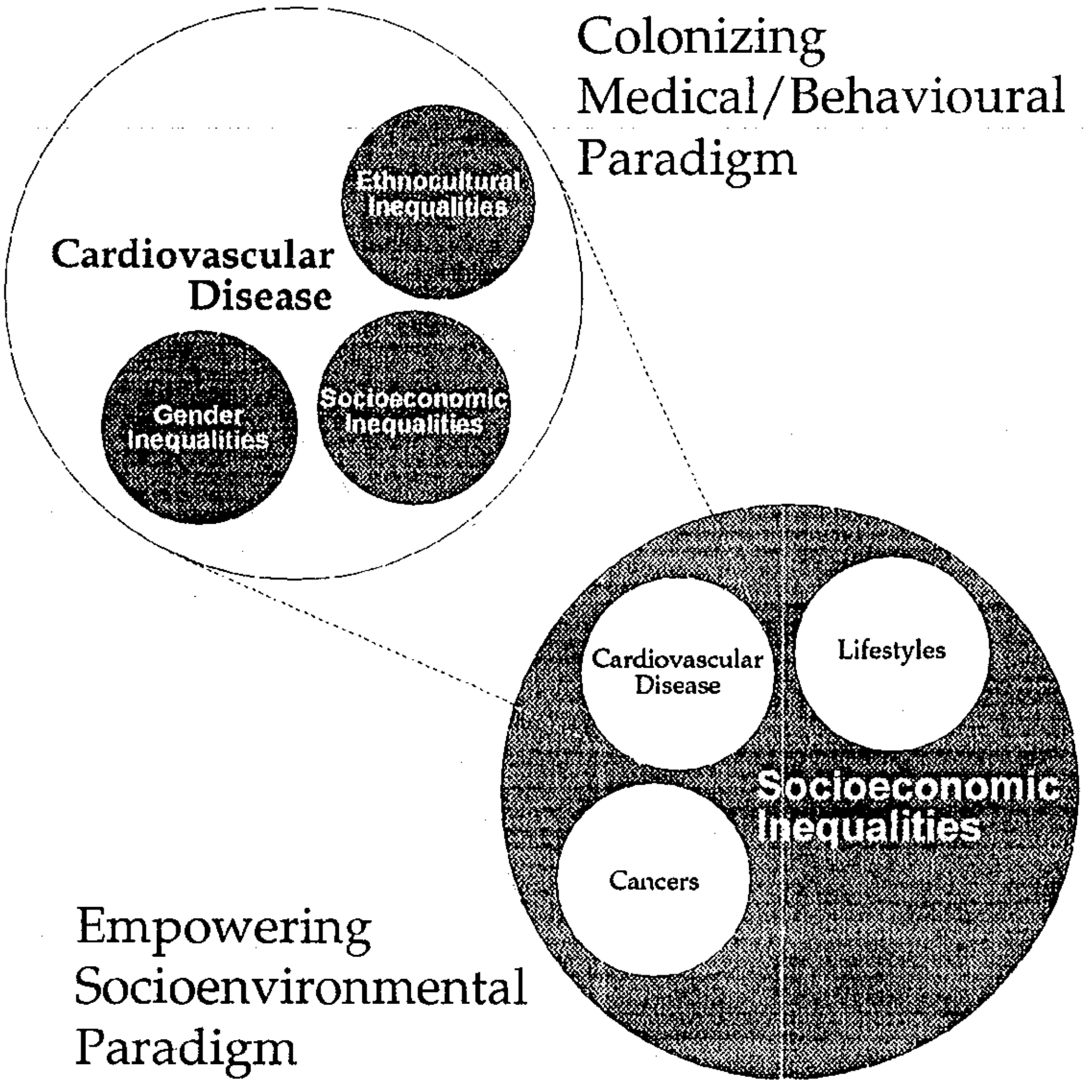
3. Quantitative measures are utilized when appropriate, but much of the evaluation relies upon qualitative methods. The distinction between "process" and "outcome" blurs as, in many instances, the process is the outcome.

Community-based and community development programming are presented as stereotypes. Many health promoters may begin from a community-based approach (e.g. heart health programs) yet proceed in a community development fashion. For example: Many persons in poor city neighbourhoods today (and yesterday, and likely into tomorrow) would express unemployment and poverty as their greatest concerns. But health promoters eager to tackle these grander health determinants may find residents reluctant to struggle (yet again) against complex social structures of oppression, manifesting the learned helplessness or apathy that is often an empowering health promotion practice's first concern.

One heart health program tells of community residents who, by participating in educational projects (heart health) **beyond** their more deeply felt experiences (poverty, unemployment oppression), began to move through their sense of helplessness. It was easier for locality residents to organize and experience some successes around issues of nutrition or fun-runs than around poverty. These successes buoyed them to begin (yet again) tackling the more deeply rooted problems of their social status and condition. They reflect what other researchers have called the "minimum success paradigm" (Texidor del Portillo 1987), the fact that most people "don't want to make history, but simply make life." (Minkler 1985b) Emphasizing lifestyle change will not always be an effective organizing metaphor; whether it will be depends upon the reference frame (paradigm) through which the health promoter views her community groups, her relationships with them and the nature of their concerns or problems.

An anecdote is often used to illustrate the theory-laden, or paradigm bound, nature of observation. Two astronomers view a sun-rise. They agree upon the basic empirical facts of their observation. One astronomer is pre-Copernican, and sees the sun revolve around the earth. The other astronomer is post-Copernican, and sees the earth revolve around the sun. Similarly, two health promoters are developing heart health (community-based) programs. One sees her clients in terms of cardiovascular disease outcomes. The other sees his clients in terms of their lived experiences. Outwardly, the programs may appear to be similar, at least initially. But in the former case, health never transcends its encasement by disease. In the latter case, heart health is merely one entry metaphor into the much richer, more complex experiences of people, which include their historic, gendered, class-based and cultural forms of oppression, expression or liberation. In the former case, when people express concerns about these oppressions the health promoter is either deaf or shrugs that it is not heart health, not in her mandate. In the latter case, the health promoter asks of himself: What can I do to support these persons in these other endeavours? (See Figure 6) The difference lies in the professional's authentic commitment to hearing the experiences of people's lives, to understanding

Figure 6: Colonizing and Empowering Paradigms



The colonizing paradigm views social inequalities as factors that enable/disable disease prevention goals. The empowering paradigm views disease prevention issues as entry points into actions on more broadly experiences aspects of social inequalities.

these experiences in the words people use to express them and to negotiating mutual actions to improve those situations people would like to alter. The authenticity of this commitment is contained in the challenge of Lily Walker, an Austalian aboriginal women.

"If you are here to help me," she said, "then you are wasting your time. But if you come because your liberation is bound up in mine, then let us begin." (cited in Valvarde 1991)

Criteria for Success

An empowering health promotion practice holds that certain community processes (organization, mobilization, education) are necessary to enhance personal health and to create environments that are simultaneously more protective of health and more supporting of healthy personal behaviours. Not only does this require a reformulation of what success looks like; it also demands a different epistemology and methodology of research and evaluation.

Wilber (1981) discriminates between three major epistemologies:

* empirical/analytical: Real facts exist independently of our perception of them; this is useful for the study of material world objects.
* phenomenological/hermeneutic: Individual perceptions of phenomena become socially constructed models of reality, that are then interpreted; this is useful for the study of the mental and social world.
* paradoxical/mandalic: Certain experiences are ineffable, understandable only in paradox or prayer; this useful for the study of spirit.

While health promotion may soon have to wrestle with the third epistemology (the "spirit" aspect of the mind/body event we experience as "self"), it is currently grappling with the first two. Elevated serum cholesterol levels belong to the realm of material world objects; the quality of social relationships, and even the experience of health, do not.

Yvonna Lincoln and Egon Guba have devoted considerable intellectual energies to clarifying the distinctions between the first two of these three epistemologies. (Lincoln and Guba 1985, Guba and Lincoln 1989) The empirical/analytical epistemology they call "conventional" and typify it as the positivist, reductionist approach to inquiry. Other attributes of this particular paradigm are:

* its adherence to the belief in a single reality independent of any observer's interest
* its mechanistic explanation of causality
* its presumption that universal truths can be found

Its epistemology is the characteristic "subject/object" dualism that holds the completely detached observer in highest research esteem. Its methodology strives to control for multiple variables, slowly stripping the reduced item under inquiry from its confounding context. The conventional paradigm is generally labelled the scientific method. Its recent origins lie with the dualist philosophy of Descartes (the separation of mind from body) and the mathematical mechanics of Newton (Prigogine and Stengers 1984). Contemporary physics challenges much of this paradigm's assumptions about "reality"; events at the subatomic and cosmic scales do not occur in strictly mechanical or context-free ways. Its continuing predominance in the middling level of human life and experience can be accounted for by the "logical possibility" argument. The conventional paradigm has proven so successful at allowing accurate predictions that, given time, it should be able to tidy up those remaining murky areas of human knowledge. One sees this argument in Carl Sagan's evocative statement that, "My fundamental premise about the brain is that its workings – what we sometimes call 'mind' – are a consequence of its anatomy and physiology and nothing more." (cited in Foss and Rothenberg 1988, p.46)

In sum, the conventional paradigm is concerned with prediction via proof (certainty). We see applications of this paradigm in epidemiology, behaviourist psychology and social marketing, among other health promotion "feeder" disciplines.

The phenomenological/hermeneutic epistemology Lincoln and Guba call "constructivist." The constructivist epistemology begins with the fundamental belief that there exist multiple, socially constructed realities ungoverned by any universal laws. Truth is no longer immutable, but the best informed and most sophisticated statement of understanding for which there is a reasonably high degree of consensus. Or, as 17th century Quaker, Isaac Pennington, noted, "Every truth is substantial in its own place, and all truths are but shadows except the last." (cited in Frye 1991, p.20). The epistemology of this paradigm coheres with its fundamental belief: The inquirer is interlocked with the item under inquiry, rendering the findings a creation of the inquiry process rather than some extruded fact. Its methodology, in turn, is hermeneutic (interpretative); it is a process of iteration, analysis, critique, reiteration, reanalysis, synthesis and so on, leading to the emergence of some shared understanding of a "case" or set of relations. It is interesting to note that this methodology analogizes the various "conscientizacion" steps in critial pedagogy theory (Freire 1968), and various models of community development and empowerment, all of which figure prominently in conceptualizations of the "new" health promotion.[4]

In sum, constructivist methodology is concerned with meaning via knowledge (understanding). We see applications of the constructivist paradigm in critical or interactive approaches to education, community development, community psychology (empowerment) and other social science feeder disciplines to health promotion. (See Table 7 for a comparison of the two paradigms of inquiry.)

Table 7:
Two Paradigms of Inquiry

THE CONVENTIONAL PARADIGM	THE CONSTRUCTIVIST PARADIGM
Ontology	**Ontology**
Belief in a single reality independent of any observer's interest. Mechanistic explanation of causality. Presumption that time/space context-free universal truths can be found.	Relativist, i.e. there exist multiple, socially constructed realities ungoverned by any universal laws. Realities are "socially and experientially based, local and specific, dependent for their form and content on the persons who hold them." Truth is the best informed and most sophisticiated statement of understanding for which there is a reasonably high degree of consensus.
Epistemology	**Epistemology**
Subject/object dualism. Researcher as detached observer. Accepts possibility and desireability of excluding researcher's values biases in inquiry.	Inquirer is interlocked with the item under inquiry, rendering the findings a creation of the inquiry process itself.
Methodology	**Methodology**
Interventionist (experiemental/manipulative). Hypotheses stated in propositional form and subject to empirical (falsification) tests. Strives to control for multiple variables, rendering the variable of interest context (confound) free.	Hermeneutic (interpretative), and dialectic (dialogue, constant comparison of differing interpretations). Iteration, analysis, critique, reiteration, reanalysis, and synthesis leading to the emergence of some shared understanding of a "case" or set of relations.

Source: Lincoln and Guba, 1989.

Social causation differs considerably from physical or quasi-physical causation, and its multidimensionality renders any understanding of it much more fixed in place and time. (Arnoux and Grace 1991) That social relations (the stuff of health promotion as an empowerment project) are poorly understood using a conventional paradigm does not mean that this paradigm is without usefulness in such a practice. Inquiries using this paradigm can provide a certain type of information that, together with information ("data") gathered through constructivist (naturalistic, qualitative) inquiry, allows all project participants to understand more fully what they have done, and how well they have accomplished its doing. For health organizations, however, it requires a willingness to suspend their sedimented belief in the supposed hardness of quantitative data.

Consider a situation where a researcher is studying the effects of community connectedness on the experience of health, a relation of some interest to post-**Ottawa Charter** health promotion. She draws together a number of persons into a series of focus groups, in which she elicits detailed, experiential information on participants' evaluations of their community connectedness and their experiences of health. She could, if she wanted to, attempt to quantify this information and analyze it as if the results she obtained were somehow uncontaminated by the groups she formed, the questions she prompted, and the interactive construction of information that arises when groups are collectively interviewed. (That is, as persons shared their experiences they expanded or delimited the recall and range of other persons' experiences.) But she would do better justice to her methodology if she interpreted her findings as a particular construction of meaning for those particular groups, a construction she herself participated in creating.

Now let us assume that another researcher creates a survey instrument, developed in "grounded theory" fashion (Glaser and Strauss 1967) from the results of the first researcher's focus group. He administers the survey randomly, and then analyzes and interprets the data using statistical techniques common to the conventional paradigm. He finds strong statistical correlations between, say, participation in neighbourhood committees and self-reported health, and concludes that this finding should now be researched prospectively with suitable controls for other factors that may affect self-reported health. He may even call for a randomly selected sub-sample of experimentals (those involved in neighbourhood committees) and controls (those not involved in neighbourhood committees) for physical health examinations, to validate the health self-reports.

Clearly, there are two differing epistemologies at work, the first seeking to know by understanding how persons connect their experiences of health with their experiences of community; the second seeking to know by hypothesizing that certain specific forms of social group participation independently predict lower disease risk. Both types of knowing contribute to our understanding of the relationship between community connectedness and health. Both methodologies of inquiry can be reviewed for their degree of epistemologically appropriate rigour. Both findings can be interpreted and communicated to the field through the lens of their respective paradigms. Both findings also lead to differences in how health departments might construct their interventions.

While it is not unusual to find conventionalists adopting qualitative methods (e.g. focus groups) it is also usual to find these conventionalists regarding the results of these inquiries as preliminary only, providing them with the necessary constructs that they will then isomorphize into categories, much as our second researcher did. These categories will then be rendered into instruments amenable to the "more" scientific task of randomized application and sophisticated statistical analyses. That this involves three or more levels of abstraction from the original lived experiences of people, and that we then regard such abstractions as "hard" data while impugn the detailed reports of "lived experience" as "soft" data, attests eloquently to the dominating power of the conventional paradigm in its ability to stand "reality" on its head. What could be harder, more firm, more meaningful, more significant, than people's accounts of their own experiences?

When one seeks certainty established through statistical means, the relation under study can only represent a very small piece of the larger whole of human relations and experience. By creating a randomized survey on community connectedness and health we significantly delimit the range of potential meanings that would arise from a focus group inquiry. We examine only one particular of a far denser whole. But when a broader swathe of human relations and experience are the subject of inquiry, when we seek to listen to a nearer-totality of peoples' experiences as they most broadly state them, methodologies of statistical certainty must yield to constructed notions of consensus, of "best understanding." Health organizations and their information specialists must begin to accept survey data and other information gathered through conventional means as simply one type of knowledge to be apprised alongside other information gathered through other paradigmatic methods of inquiry. The policy, programming and evaluative significance of such informations will not be determined through chi-square tests, but through critical interpretations and debate.

A problem nonetheless remains. How do we break free of the "hermeneutic circle" of the constructivist paradigm, the **reductio ad absurdum** through which "my reality is as good as your reality" prevents groups and organizations from choosing – as they do and must – between competing claims to "truth?" A third paradigm of inquiry, akin to the constructivist in its emphasis on lived experiences and qualitative methodology, exists, and is often called the "critical" or "participatory action" paradigm. Table 8 attempts to distinguish between these three paradigms; a few comments below clarifies the distinctions between the three in favour of the critical paradigm as the one most consistent with health promotion as an empowering practice.

Table 8:
Differing Characteristics, Three Paradigms of Inquiry

CONVENTIONAL	CONSTRUCTIVIST	CRITICAL
scientific/experimental	naturalistic	participatory/action
quantitative	qualitative	ideological
universal truths	particular meanings	"truths" and meanings in historical context
prediction, control	consensus, understanding	emancipation

1. "Scientific" can describe all three paradigms if science is understood as a disciplined inquiry. Our society, however, privileges as "science" (hence more credible, more powerful) knowledge from one inquiry paradigm, the conventional paradigm, over others.

2. "Naturalistic" in the constructivist paradigm refers to inquiry about people in their day to day situations, or at least in reasonably naturally occuring interactions such as focus groups or interviews.

3. "Participatory/action" refers to the inquirers in the critical paradigm attempting to have the inquiry guide action and follow from action, a constant iteration between action, reflection (inquiry) and action in which the inquirer and those he inquires with are partners in a political struggle over issues of power.

4. All three paradigms may make use of quantitative, qualitative or ideological methodologies. By ideological, I mean the assumption in critical social science that some beliefs are false beliefs, products of a false consciousness, representations and perceptions of reality that are predicated on power relations, the dominant ideology of socially powerful groups. The danger of ideological analysis – an approach to inquiry that assumes that all knowledge is cacooned within a set of power relations – is that **how** we interpret power relations leads our question-posing, documenting, interpreting, analyzing etc. of data. Persons in the conventional paradigm would shun this as inappropriate, biased, value-laden. Persons in the constructivist paradigm may not care too much because their primary concern is simply the lived experience in peoples' own words, whether or not it reflects a "false consciousness" or internalized powerlessness. Persons in the critical paradigm would say that both of these positions are, in fact, ideological ones, and that **all** paradigms of inquiry can only cope with this unavoidable situation by being reflective on and honest about their ideological positions.

5. The conventional paradigm focuses on correspondence (data corresponding to "reality"). The constructivist paradigm focuses on consensus (for those who are studying the problem, is this explanation the best one?). The constructivist's emphasis on consensus can lead to the trap of the hermeneutic circle, i.e. "our findings about this issue **only** apply to **these specific people** in **these specific circumstances** and we can't generalize them at all to larger social groups and conditions." The critical paradigm accepts the theoretical impossibility of generalization, but holds as a political or ideological priority the need for all inquirers to talk about what may or may not be generalizable to broader aspects of the human condition, so that actions that would be emancipatory of large numbers of people can be undertaken, and undertaken more effectively.

6. To some extent, all paradigms of inquiry are concerned with prediction/control and with understanding. It is the **emphasis** that the conventional paradigm places on prediction and control that demarcates it from the other two. Understanding or consensus in the constructivist paradigm embodies an ideal, as well as a belief that reality is the best agreed upon ordering of perceptions that we as a group can manage at this time. Another metaphor used to describe the constructivist paradigm is "solidarity," – something that heightens the perception of interdependencies amongst all stakeholders, all respondents/participants. The emancipatory outcome of the critical paradigm is similar to that of the constructivist, but with the twist of a political project that is primarily concerned with creating more equitable structures of social relationships. In the constructivist paradigm, when there is no consensus possible, the inquiry is abandoned; there is a momentary closure on the learning potential of the inquiry. From a critical paradigm perspective, however, this dissensus may represent a crystallized learning moment, as a fundamental conflict in power relations is "discovered." This discovery is part of an emancipatory process for less powerful persons or groups.

These paradigmatic differences are itches that fester strongest in how health promotion activities, especially those concerned with empowerment, are evaluated. In general, sophisticated evaluation designs (pre- and post designs, cohort or quasi-experimental designs) often fail in health promotion evaluations for lack of participation. (Labonte 1993) Many powerless persons resent the intrusion, do not understand why the questions are asked and do not complete the surveys. Quantitative evaluation (surveys, validated questionnaire instruments, pre/post or quasi-experimental designs, etc.) are often irrelevant or inappropriate to most empowering health promotion projects. They tend to ask questions that are not terribly important to the quality of persons' lives; or they represent a disempowering form of surveillance, defining people through administrative categories that have more relevance to the management of social "problems" than to the emancipation of oppressed or powerless groups.

Endnotes

[1] There is something both emancipatory and disempowering about the notion of health determinants. On the one hand, recognizing that poverty, unemployment, income inequalities (in a phrase, social justice issues) and various toxics and environmental impacts (in a phrase, ecological sustainability issues) directly and indirectly affect health allows health professionals to expand their own practice. It permits us to question with some rhetorical legitimacy historically skewed power relations, and to posit the most healthful allocation of social resources, i.e. away from high-technology medical interventions and towards low-technology "community empowerment." On the other hand, the box-like nature of many health determinant models (e.g. City of Toronto 1991; Evans and Stoddart 1990) is hand-in-glove with an atheoretical, empirical social epidemiology that still defines people by categories of interest to institutions, and leaves unproblematic and unexplored the power relational dynamics between the state and community groups.

[2] There is even a problem with "problem." People may not experience disease, poor health behaviours or even unhealthy or oppressive conditions as problems, and may describe them simply as concerns or issues. When we refer to these issues as problems, we overlay the concern or issue with a negative valuation, often with a connotation of something that requires others (i.e. ourselves, our agencies) to remedy. The same implicit valuation occurs with even greater vigour when we refer to "needs assessments" and "needy" groups, terms which convey a deficit situation and a superiority between the professionals making the assessment and those so assessed. As we shall see later, a bureaucrat's perception of need may be community group's perception of right.

[3] One could add an iterative loop between activities and outcomes, into which process evaluation would be inserted. But this iteration still presumes the initiating goals and objectives are those against which the endeavour should be judged; and most process evaluation within this loop comprises non-rigorous forms of description or endless reams of quantitative administrative data that shed no light on how well the actors' intentions (whether professionals, community group members, and/or agencies) have been acted upon. One social worker in a drug rehabilitation agency complained in a workshop of having to complete process evaluation forms. These forms did not ask questions about the nature of the counselling relationship, the insights gained by the client, the client's ability to articulate her issues, or even her ability to integrate into main society through employment or education programs. It was simply about, "how long?" "how many?" "number of referrals to other agencies?" and the like. Quantity, not quality. Not even quality quantified. The more difficult the client, and the more the social worker engaged in a good counselling relationship with the client, the worse the process evaluation appeared. Ideally, agency managers and fundors would need to internalize the importance of quality and to challenge the "bottom-line" market ethos that has colonized so much of human service work. In the meanwhile, the workshop struck an innovative deceit: Define each client interaction hour as a unit. Assign weighted values to the units: A difficult client is worth 3 units per hour, an easy client worth only 1. Include the occassional group educationals as client interaction times. Pretty soon the numbers become very impressive! And the deceit is only partial, since such a weighting of numerical value has far more theoretical and empirical support than the simple counting that passes for process evaluation.

[4] While the problematic of paradigmatic "fit" remains (e.g. a conventional paradigm is a poor fit with most empowerment projects, though it may complement the constructivist paradigm), the issue of paradigmatic rapprochement is fundamentally one of professional

intent and practice. How do we "interpret" our professional/organizational actions within the panoply of social actions concerned with the **Ottawa Charter**'s basic health prerequisites of "peace, shelter, education, food, income, a stable ecosystem, social justice and equity." This is where the epistemological issue arises once again, for an epistemology of detachment (conventional paradigm) sweeps the question of professional intentionality under the carpet of false objectivity, while an epistemology of engagement (constructivist paradigm) places the question at the centre of the research and evaluation inquiry itself. Indeed, there is a striking convergence in professional role definition within empowerment (Rappaport 1987), community development (Rothman and Tropman 1987), critical pedagogy (Freire and Macedo 1987), constructivist research (Guba and Lincoln 1989), critical psychology (Sullivan 1990) and even interorganizational collaborative theories (Gray 1989). A few aspects of this emergent professional reconceptualization include:

- facilitating
- enabling
- explicitly concerned with creating more equitable power relations
- sharing personal values statements
- seeking consensual decision-making
- "midwiving" a search for meaning
- critically self-reflective
- empathic
- an involved "stakeholder" with a "claim" to the outcome

Other readers of the literature may choose slightly different descriptors of this emergent role; by definition, the role virtually defies rigid typologizing. At its core, however, is the notion of an emancipatory, political project. Many persons involved in such projects work quite comfortably and quite well with the conventional paradigm, consciously or unconsciously bracketing its epistemological detachment. The inherent political nature of **all** science, however, including that conducted with the conventional paradigm, must become more explicit. As Tesh (1988) argues, the task is not to take politics out of science, but to "get the politics out of hiding." (p.177) This is easier with a constructivist paradigm, but not impossible with the conventional paradigm. It is more difficult with the conventional paradigm, however, because of its assumption that inquiry (research) can somehow extract from "Nature" its rules, laws, facts that are reasonably immutable. In an era when scientific certainty about many phenomena is unlikely or even theoretically implausible (notably where physical environmental change due to human resource use and pollution is concerned) this assumption assumes a disabling, disempowering prominence in political discourse. Waiting for sufficient "facts" to be generated is a convenient way to maintain status quo social structures and obscures in a haze of scientism the political nature of most public policy decisions. When these points were discussed in a session on "critical epidemiology" at a recent New Zealand public health conference (Hamilton, New Zealand, May, 1991), epidemiologists quickly pointed out that they always qualified the limitations of their research findings, implying that they were not to blame for the political tendency in hard situations to defer to "factual data" or their absence. But these epidemiologists had missed the point. Epidemiological qualifications are almost invariably expressed within the framework of the conventional paradigm (e.g. weak statistical association, the limits of correlational data, the need for replication, generalizability beyond experimental group, biological plausibility, abnormalities in dose-response gradients, "confounding" factors, alternative hypotheses, etc.). These qualifications nonetheless leave implicit the assumption that, given sufficient time, sufficient "facts" may be ascertained to provide the "right" answer to the policy conundrum. It is this assumption that the constructivist paradigm, with its emphasis on interpretation, ethics and morality, fundamentally challenges.

Chapter 3: Exploring Empowerment

Many models of empowerment exist (e.g. Kieffer 1984; Morgaine 1988; Lord and Farlow 1990; Lord 1992) and I will not review them here. Rather, I will explore what our empowerment vocabulary means by unpacking the term itself, and how we might know when we achieve it.

Can I Empower You or Shall You Seize Power For Yourself?

Empowerment is one of those slippery "E" words alongside equity, equality and enable that, on good days, makes us feel more capable and happy in our work and, on bad days, makes us squirm to the sounds of a thousand finger nails scratching upwards on a chalkboard. The reason for this duality may be simple: Empower, the central act in health promotion, has a split personality; it is both a transitive and an intransitive verb. Used transitively, empower means bestowing power on others, an enabling act, sharing some of the power we might hold over others. This is an important aspect of empowerment. It casts the act as an inherently relational event. Empowerment exists as a shifting or dynamic quality of power relations between two or more persons, such that the relationship tends towards equity (fairness) by reducing inequalities (differences) in access to the instruments of power (e.g. property, income, access to economic and political decision-making structures, and other socially created vehicles that act as controls over personal choice).

But there is a danger in our use of empower's transitive meaning. We, as the empowering agent, the subject of the relationship, remain the controlling actor, defining the terms of our interaction. They, the relatively disempowered individuals or groups, remain the objects, the recipients of our actions. As poststructural and postmodern theorists warn, our language exerts considerable force in our world constructions. (Seidman and Wagner 1992) In mundane terms, continually stating "we need to empower this or that group" creates and reinforces a world of professional practice in which non-professional groups are incapable of their own "powerful" actions. This danger is illuminated by the intransitive meaning of empower: The act of "gaining or assuming power." (Compact Edition of the Oxford English Dictionary, 1971, p.855) Empower used in this sense is reflexive; it takes no object. Rather, the subject is the object. To some, this meaning of empowerment should stand as its litmus test. The only empowerment of any importance is the power seized by individuals or groups.

But even if we confine our use of empower to its intransitive sense, there can be at least two conceptualizations of the subject: Ourselves, and our clients. When we are subjects empowering intransitively, our role (as professionals) is to claim more power for ourselves; if we do so with the intent to transform oppressive social structures, rather than to advance professional self-interests, this is an emancipatory act. This is an important and often neglected facet of our work, usually reduced to endless complaints against our own organization and managers as displaying all of the power-over tendencies disavowed by health promotion rhetoric.

The Professional as Self-Empowerer in Relation to the Client

Many of us are relatively powerless in our organizations, and need to claim a legitimacy or power for ourselves in order to be effective in our work with less powerful groups external to our organization. When professionals are not granted professional status (legitimacy), they have great "difficulty in establishing a reflective [empowering] contract with their clients" because they lack "enough voice in the situation to be able to do so." (Schon 1983, p.298) Much of the disabling power-over tendencies within professional practice may simply reflect an acting out of our own professional disempowerment, or the self-evident truth: One must have power in order to share it.

Community development, as a pertinent example, has been pithily if cynically described as the point at which the organizationally powerless meet the socially powerless. Organizations that do not engender internal democratic participation tend to have poor, power-over relations with external groups and other organizations. (Lackey etal 1987) When workers do not feel esteemed in their jobs (i.e. they feel "low status") they tend to derogate, or victim-blame, the less powerful persons and community groups with whom they work. (Finne 1982) Where health promotion as empowerment is concerned, it is not "practice what you preach." It is, "if you do not practice, you cannot preach," full-stop.

Kilian (1989) and Katz (1984), among many others, are less than sanguine about the opportunity for professionals to act in empowering ways. Stated more baldly, "the word "empowerment" and the word "professional" must not be used in the same sentence – the two are in absolute contradiction!", ironically, the words of a community development professional. (cited in Barr and Cochran 1992) But as Schon (1983) observed, many clients engage in a relationship with a professional on the presumption that the professional has a body of expertise, a certain legitimacy and power. This legitimacy **can** lead to abusive power-over relationships. But critics of institutional power-over tendencies frequently fail to distinguish between the setting and the practitioner, the result being a disempowering critique of the professional role even when that professional is struggling to act in a more emancipatory fashion. This, Schon argues, leads to two remedial strategies only: A new breed of professional advocates who mediate between the old professionals and the powerless client-victims, or a new breed of citizen-practitioners who simply take over the territory previously held by the old professional group.

This non-dialectical thinking also leads to calls for new community service institutions with greater citizen participation. It is now axiomatic in many government funding programs that citizens be actively involved in new service projects. One project, funded for five years, is training lay women to work as pre- and postnatal home care workers, replacing the work previously done by public health nurses. Nominally, the intent is to increase the effectiveness of such programs through peer support and facilitation of "natural" networks. But the pilot projects have floundered on Schon's precise shoals. There has been little rigorous exploration of what had been ineffective or disabling about past professional and institutional service provision. This risks creation of a **new** but no less disabling substitutive service. Moreover, historic service providers are withdrawing from pilot project areas which, of course, are low-income areas. When the five year pilot funding runs out, there will be **no** services, disabling or otherwise!

The Client as Self-Empowerer in Relation to the Professional

If empower is used intransitively, and the subject is our client, our professional role is to ensure a relationship such that power can be taken. Professionals generally **do** have more power than their clients. How is this power shared or given up in ways that do not become stuck in patronizing? How is power taken from those in empathy with relatively powerless individuals or groups in ways that do not become stuck in anger or resentment? These questions underpin all struggles for equity that exist simultaneously at the interpersonal and social (intergroup) levels, e.g. between women and men, between indigenous and colonizing peoples, between economic or status defined social classes. Empower in these struggles is both transitive and intransitive. Women take power back from men within their personal relationships; feminism as a social movement redistributes social/institutional power more equitably between men and women. But if men in relationships are not prepared to give up power (that is, to allow power to be taken by hearing the critiques made by their female partners) the relationship is likely to end in conflict rather than commit to growth and transformation. Policy reforms similarly owe partial success to men in institutional decision-making roles accepting feminist movement demands.

The empowering act exists only as a relational act of power taken and given in the same instance. The tension of this invoked in professional practice became identified as power- over (a term that already suffuses this monograph) and power with. (Table 9)

Table 9:
Power Over/Power With

POWER OVER	**POWER WITH**
the reality of things	the reality of experience
tolerance	respect
education to our terms	dialogue for shared meaning

Power-over relies upon the reality of things – diseases, health behaviours, risk factors. **Power with** looks to the reality of lived experience in the language, images and symbols that people use to give voice to them. (We see more clearly here the power relational elements of the conventional and constructivist paradigms of inquiry outlined in the previous Chapter.) **Power-over** tolerates other's views. **Power with** respects other's views, trying always to hear them in the larger context of the other's entire life. **Power-over** tries to educate others to his terms, his ways of viewing the world. **Power with** tries to find some common ground between what she knows, and how she talks about it, and what communities know, and how they talk about it.

Power and Empowerment

Given the prominence of empowerment in health promotion discourse, it is surprising how little the concept of power has been addressed. (Labonte 1989b) At its simplest power, is the exercise of choice.[1] Many workshop participants found this simplicity inadequate to give vocabulary to the varieties of power in their practices, e.g. power-over forms of dominance or exploitation, power with forms of mentoring. Foucault's concept of hegemonic power proved particularly useful in moving through the determinism of the behavioural approach to health (you are your lifestyle behaviour) and the more socially critical but no less deterministic socioenvironmental approach to health (you are your socioeconomic category). (Foucault 1979) Hegemonic power refers to the ability of a dominant group to control the actions or behaviours of others, in health promotion's case through the power of defining the nexus of health problems within which persons experience health or well-being. Hegemonic power is that form of power-over that is invisible, internalized, structured within the very nature of our day-to-day living so that we come to take it for granted. This internalization leads to false consciousness, "failing to utilize the power that one has and failing to acquire powers that one can acquire," (Morriss 1987, 94), which others have called learned helplessness (Seligman and Maier 1967, Seligman 1975) or surplus powerlessness (Lerner 1986), and which health promoters sometimes describe as the apathy of the poor.

Table 10: Knowing When We Get There

For all persons in the empowering relationship

- improved self-esteem and cultural identity
- improved ability to reflect critically and to solve problems
- improved ability to make choices
- improved self-discipline
- improved ability to work with others

For less powerful persons in the empowering relationship

- increased access to resources
- increased collective bargaining power
- increased legitimation of one's group demands by officials

Adapted from Kindervatter (1979)

Learned helplessness is a psychological construct that emerged from Seligman's and Maier's animal research in the 1960s. (Seligman and Maier 1967) Dogs were subjected to inescapable electric shocks; when the barrier preventing their escape from these shocks was removed, the dogs continued to withstand the electric shocks and did not seek escape. Even if they accidentally avoided the shocks, they did not internalize this learning and continued to withstand subsequent shocks. They had resigned themselves to their fate. Lest we resign ourselves to learned helplessness, the dogs did "re-learn" how to escape after repeated "teachings" by the researchers, in which they pushed, pulled or prodded the dogs away from the area being shocked. Seligman has now coined another term, "learned optimism," to encompass the dynamic of learning how to develop positive self-images. Treated superficially, however, this notion lends itself too readily to a self-empowerment, bootstrapping approach to social injustices.

Lerner (1986) argued that a similar phenomenon occurs with relatively powerless persons, i.e. persons living in risk conditions. He named this process "surplus powerlessness," a surplus created by, but distinct from, external or objective conditions of powerlessness. Individuals internalize this objective powerlessness and create a potent psychological barrier to empowering action. They "do not even engage in activities that meet their real needs. They begin to accept aspects of their world that are self-destructive to their own health and wellbeing, thinking that these are unalterable features of what they take to be "reality."...." Part of this internalizing process is isolation, removing oneself from active group participation because of low self-esteem.

Self-blame and internalized anger are aspects of low self-esteem, and are correlated with poorer self-reported health status and increased behavioural risk factor prevalence. Lerner believed that specific group education could overcome self-blame while improving health status and health behaviours. His research involved blue collar workers experiencing occupational stress. Persons in the experimental occupational stress groups demonstrated statistically significant improvements in the predicted direction on all of the measures used compared to controls. The key construct, self-blame, decreased significantly as social support behaviours among stress group participants improved. That stress groups took place under union sponsorship may have been an important factor. Many stressors are embedded in the structure of work; actions to remedy this problem requires an organized, political effort. Unions, through their collective bargaining, afford individual workers an opportunity to take collective actions on the "structural" elements of work (i.e. the risk conditions of work) while the stress groups improved social support and coping behaviours.

Empowerment as a Beneficial Experience

The discussion to this point requires that we reject simplistic dualisms, as in "personal (self)- empowerment" versus "political empowerment." It requires a practice that simultaneously attends to the psychological or subjective experience of powerlessness (the experience of Foucault's positive power-over), while organizing actions directed towards the negative aspects of power-over (the external objective powerlessness of exploitation or domination). This dynamic underpins the strategy model that follows in Chapter 4. It is predicated, in part, on arguments within the social movement literature that isolated, atomized or otherwise alienated persons (those experiencing the greatest internalized powerlessness) are the last persons to participate in collective actions to change those conditions. (Oberschall 1973) Such actions and mobilizations originate with reasonably well-integrated persons. An empowering health promotion practice therefore **must** be concerned with empathic (and presumably integrating) client services, at least to the same extent that it provides resources for, or participates in, organizing, advocating and mobilizing actions.

While it is incumbent upon us to pay greater analytical attention to our (usually implicit) conceptualizations of power, the discussion so far has only concerned itself with power-over. Table 11 extends the horizon of power so that it can incorporate the beneficial aspects of power that are of central concern to an empowering health promotion practice. If we accept that moral power is the heart of Morriss' three other power descriptions in this Table, empowerment can be said to exist simultaneously at three interpenetrating social levels.

Table 11:
Power Experiences

1. power within
   - self-efficacy
   - "what can I do?"
2. power between
   - supportive or exploitative/dominating
   - "what can you do for me?" (supportive)
   - "what can you do to me?" (exploitative/dominating)
3. power amongst
   - evaluative
   - "how good is the distribution and amount of power here?"
4. moral power
   - ethical
   - "could you have prevented [something bad] from occuring?"

Adapted from Morriss (1979)

1. At the intrapersonal level, it is the experience of a potent sense of self, something that enhances self-esteem and self-efficacy; it is "power within," the experience of choice.
2. At the interpersonal level, it is the construction of knowledge and social analysis based upon personal and shared experiences, enhancing a critical consciousness of the social structures of power-over, and increasing self-potency through affirmative social support that pierces the positive power-over of internalized powerlessness; it is power with, the experience of interdependency.
3. At the intergroup level, it is the cultivation of resources and strategies for personal and sociopolitical gains, enhancing advocacy and participatory democracy, creating greater social equity; it is power between, the experience of generosity as the Sufis define it, "doing justice without requiring justice." (Shah, 1990; p.182)

These levels are not discrete. There is no "power within" that exists separate from "power with," or distinct from "power between." The limitation of notions such as self-esteem and self-efficacy is not that they focus on the individual, but that they presume that individual identities exist separately from social or group identities. The limitation of critical consciousness, of the formation of strong group identities based on conflict relations with more powerful and power-overing groups, is that it may fail to accept some larger moral notion of a common good embracing all humanity. The limitation of generosity is that there has been scant evidence of transformations in social power-overing behaviours without some political conflicts between groups.

The potential usefulness of separating out these levels is recognizing that an empowering health promotion practice is not restricted to work with individuals, nor to work with groups, nor to work with social institutions or structures, nor to work with policies and political processes. It attends to all of these levels, with professional actions and program purposes that may be quite different at each level, yet be united by professional actions, program purposes, outcomes and effects that deliberately strive to link across all of these levels. This separateness and this linkage of levels and strategies is precisely what is modeled in the following Chapter.

Endnotes

[1] We must also recognize that the rhetoric of choice can become an excuse for professionals or politicians to avoid making difficult decisions. Some choices, especially those offered by the commodifying marketplace, often in the name of the empowered consumer, are meaningless. How many banking options, telephone features or cable television combinations should we care about? These trivial choices can also overwhelm us with detritus, taking attention away from more critical areas where we have no choice. The same dialectic can arise in non-market relations, characteristic of the helping professions. In some instances, to offer a person in crisis a range of choices – whether as a primary care provider, a health promoter, a community organizer – risks overwhelming that person in complexities. While the offer should be available, it should not be forced, anymore than it should be withheld. Empowerment as citizen/consumer choice is not as straightforward as it first appears!

Chapter 4: The Empowerment Holosphere

There is no single path to an empowering health promotion practice, I will now consider a path, a practice model that emerged processually during the training workshops. (Figure 7)[1] While the Empowerment Holosphere links actions around all five spheres, no one professional possesses the skills (or time) to work in all five spheres. The Holosphere represents an imperative for the organization as a totality. One may find many organizations offering services in the personal and small group spheres, but none in the spheres in which social action begins to emerge. Or one may find organizations acting as advocates, or as political change agents, while offering only informal supports (if any at all) for personal crises or small group needs. The point of the Holosphere is to make clear the professional and organizational necessity to seek (identify, nurture) linkages between these differing social levels of action.

Personal Care

This sphere is the one at which most front-line workers encounter individuals living in relatively powerless situations; it is the venue of direct service. McKnight (1987) has aphorized that "resources empower; services do not." This witty play on the disabling tendencies of large institutions has led to an undercurrent within the health promotion sector that would see us "empower communities" by scrapping our current methods of health and social service delivery and handing the money we thus save to poor communities. This sentiment denigrates our own community of caring professionals and reinforces a "we/they" polarity that creates and reinforces a false cleavage between "professionals" and "community members," the former being bad, the latter being good. The irony of this cleavage lies in the prominence most social movement research places upon the formative mobilizing role played by professionals, intellectuals and others who participate in social justice actions more by dent of "conscience" than by virtue of "beneficiary" status. (Zald 1988) Moreover, money **per se** may be less a health determinant in its instrumental use – to purchase commodities – than in its psychological interpretation as social status or relative importance. (Wilkinson 1990) Objective poverty/powerlessness becomes subjectively internalized. Changing the external conditions – giving the poor more money – without also creating healing or therapeutic

Figure 7: The Empowerment Holosphere

opportunities for changing the internal conditions may lead to the fearful prediction of far right apologists for the rich: It will throw "good" money after "bad."

It also risks denying persons what they often require and request: Respectful services. One Canadian health centre, imbued with the gospel of community health promotion, mistakenly drove a wedge between its clinical workers and its community workers, reversing the historic tables by extolling the importance of community development over medical care. The dissatisfied clinical team suffered rapid staff turnover, the poor neighbourhood lost its continuity of care, the health centre lost some of its empowering credibility.

The two pillars that allow service delivery to be empowering are, first, that it is offered in a supportive, non-controlling way and, second, that it is not the limit of the resources offered by the agency. The combination of these two pillars has been referred to as "developmental casework." In contrast to more traditional forms of casework or case-management, "developmental casework is **developmental**, with an explicit goal the development (empowerment) of the individual receiving the support, and the creation of links between these individuals." This approach builds towards community organizing and coalition advocacy – and hence the political elements of empowerment at the structural level remain explicit – while recognizing "that low income people have the right, here and now, to support in the face of difficulties...and that our credibility in working with disempowered groups rests to a large extent on whether or not these groups find community workers to be of **practical** usefulness." (Jackson, Mitchell and Wright 1988, p.4) This support should be offered in ways that:

* respect the autonomy of the individual
* are culturally sensitive
* seek to understand the psychosocial and socioenvironmental contexts of the individual's concerns or problems
* move constantly towards a greater capacity by the individual to act upon both the symptoms, and the roots, of his distresses

Unless we practice thinking simultaneously in both personal and structural ways, we risk losing sight of the simultaneous reality of both. If we focus only on the individual, and only on crisis management or service delivery, we risk privatizing – rendering personal—the social and economic underpinnings to poverty and powerlessness. We may offer personally empowering services but **de facto** reinforce a structural powerlessness. But if we only focus on the structural issues, we risk ignoring the immediate pains and personal woundings of the powerless and people in crisis.

Caring is the basis of an empowering professional practice; it exists now, as it always has, in the trenches of our professions, as these vignettes illustrate:

* Poor women in a state-run rooming house complain of giving blow-jobs to use the bathroom. Nobody believes them, they are just women from the streets. Their life experience has taught them the survival value of "victim." But a community health worker hears them complain. She believes their stories. She spends time with them. She advocates with them to the housing managers to create better safety in the bathrooms, and more dignity in the house.
* Many elderly persons live alone in large cities, occupying the isolating structures of high-rises that pile accomodations atop each other in non-interacting efficiency. Many of these elderly are poor, and have problems maintaining proper diets. Some nutritionists and health educators reach out to these persons by visiting them in their homes, maintaining their healthy diet by cooking with them, and sharing their meals.

- Street people are often shut out by disparaging attitudes among health workers from the institutional services to which they are entitled. They accept this, and they accept most of the indignities that come from being society's poorest. Their dignity is slowly restored, and their health cared for, when public health nurses take the personal care to where they live: In the hostels, in the 24 hour donut shops.
- New mothers are often lonely. Many of them are without the supports of extended family. Some of them have only minimal support from their spouses. Some of them have no spouse at all. Nurses break through some of this isolation, by offering pre- and postnatal visits in which the services, support and trust are brought **inside** the closed apartment doors behind which many poor women and their children remain in sickly isolation.

Caring services are essential if the so-called "hard to reach" are to be reached. (Ponder, for a moment, who is the subject and who is the object in "hard to reach;" and whether the object, the prospective client, may see herself in those same terms!) There is discussion in Ontario, Canada, about decreasing the public health nursing role in home visits, emphasizing more her role as a small group educator. But there are few other professionals with trusted access into the homes of many isolated persons. Social workers or financial aid workers often have professional discretionary powers-over, and are often viewed by social assistance recipients with greater suspicion than a public health nurse.[2] Younger street people (especially drug addicts and prostitutes) are considered "hard to reach;" yet when a useful service is provided to them (e.g. needle exchanges) they are quite easy to reach, although whether they will enter a dialogue with the professional is another matter entirely.

Small Group Development[3]

"Community" is often presented as the engine of health promotion, the vehicle of empowerment. But it may be more accurate to say that the **small group** is that locus of change, that vehicle of emancipation. "At the level of the small group, society has always been able to cohere." (Homans 1950, p.468) Nations rise and fall, institutions come and go, civilizations flourish and perish, even community organizations wax and wane, but one ineluctable aspect of humanity is its formation into small groups. To understand the **group** and its dynamics is to understand an essence of what is human. The group is where we forge our identities. The group is where we create our purpose. Only in interacting with others do we gain those healthful characteristics essential to empowerment: control, capacity, coherence and connectedness. (Wallerstein 1992) The power of the group is in creating that connectedness; the healing of the group is validating that we are not alone. This power and this healing means that when we go about our work, we must always ask ourselves: How can we assist in connecting the dots that are individuals into the squiggles that become communities? Without the support of a group, many people will be unable to participate in higher level efforts. They will remain the historically marginalized and uninvolved.

And so, developing from the vignettes described under personal care:

- A number of women roomers now meet weekly to share each other's burdens, to identify each other's strengths. The caring nurse has become the enabling facilitator.
- A group of older shut-ins in high rise isolation now pool their food and share their dining, brought together by a nutritionist who knew intuitively that eating even poor food in the warmth of others does more for health than digesting the finest quality nutrients in loneliness.
- Brought together by community organizers from a variety of service agencies, street people now constitute their own organization. Political change is part of their agenda, but simply providing each other with some emotional support and overcoming their loneliness ranks first on their list.
- A number of poor women and their young children meet weekly in a church basement, affirming that they have others they can rely upon, tracing pictures of each others' bodies, identifying their energy zones and colouring in their auras of power. The facilitating nurse has become the mediating community-builder.

We must be patient in this group-building, community creating task. It often takes between one and two years before the first "group" squiggle may form from the disconnected individual dots, group formation occurring when individuals self-identify as "group members." When Meredith Minkler and her graduate students began working with senior roomers in San Francisco's Tenderloin, it took a year of standing in the hotel lobby chatting with individual roomers, offering them counselling and an open ear, before the first group formed. (Minkler 1985b) Health workers in Ottawa, Canada, talk of how after a similar group of poor, older adults formed, they met for over a year sorting through their internal dynamics before they became interested in tackling such environmental problems as housing costs and community safety. (Labonte 1993)

This slow community-building process at the group level is not well understood by many program funders who, in the name of the **Ottawa Charter**, virtually expect new groups to move into social action and public policy with externally demonstrable impacts within the first year. As Val Gruno, director of the British Columbia Healthy Communities project, complains:

> When you put pressure on people to get results quickly, you short-change the process, don't get results, and everyone becomes disheartened. The pressure to

> get results, that's the dilemma. I hear all the time that "process" stuff is "soft," that it's not relevant to bottom-line, or that "I'm an action person." It's not that they're wrong, but we need to find ways to document successes, to provide them with information that shows change. One of the dilemmas is that the situations always seem to be so complex it's hard to capture the outcomes. (Labonte 1993)

One of the reasons why it's hard to capture the outcomes is that the wrong kind of change is often being demanded. It is perfectly reasonable to demonstrate shifts in group dynamics over the first year or two of group development, such as stronger group identity, role differentiation within the group, clarity over norms, identification of issues, management of group functions and organization, and so on. But it is less reasonable to expect that groups being newly formed should quickly turn their attentions to issues extrinsic to their own group dynamics.

We must also recognize the tension that often arises when groups begin to shift from an inward to an outward orientation. In the early years of a community garden project involving single mothers on social assistance, the women's group was split on the importance of the garden itself. (Labonte 1990) Some saw it as a metaphor, an organizing point for single mothers who, as their group strength grew, would be better able to do the important work of protest and lobbying for social assistance reform. Others saw the garden as the end in itself; empowerment existed in the simple acts of planting, tending and harvesting tomatoes. Clearly, empowerment exists at both levels, and must be supported at both levels. Often small group developers or community organizers fail to recognize that these two levels – the personal or interpersonal and the sociopolitical – are not contradictory, but complementary. We need groups that nurture the soul, and groups that challenge the **status quo**.

This cusp between small group development and community organization is particularly problematic for health promoters, or for anyone engaged in emancipatory social change. A distinction is sometimes made between self-help and community groups on the basis of direct suffering: Self-help groups buffer direct suffering, community groups look to sufferings' antecedents. (Romeder 1990) But to the extent that self-help or small groups deal only with individuals and individual problems, the deeper structural causes of powerlessness may remain obscured and unaddressed. Many self-help groups and organizations deliberately avoid sociopolitical actions, drawing a boundary between the community of direct members and their needs, and the larger social communities with which they interact. This boundary should not be breached forcibly. Personal care and small group development can be considered self-contained and important strategies, as well as essential precursors to more broadly defined community actions. Personal care and small group development are the loci of much direct social service work (case work, counselling, public health nursing); these loci need to be valued for the important supportive care and self-care they nurture.

But unless social relations are continually analyzed from a broader socioeconomic and historical framework, they may foster an odd social norm in which for many of us our **primary** social identities become forged in our disability, our disease/dis-ease, our relatively powerless social conditions. Might this represent a false consciousness of self-help? As Eddy Box, a native elder, evocatively described:

> About ten years ago, I was invited to go to an AA meeting. The first thing I saw on the wall was "I am an alcoholic." I accepted it. I said "I guess everybody does think like that." And when they come up and talk among us, they say "I am an alcoholic."
>
> After that meeting I got to thinking. And it came to my mind that when you repeat some of these words to your spirit and tell them "I am an alcoholic" no program in this world is going to help you. You're going to be an alcoholic for the rest of your life. Because your spirit has accepted that. Once your spirit accepts it, nothing helps.
>
> So, next time I went back in, they asked me what I thought of the program. I said "It think it's a good program, only the first thing I would take that sign off, the one that says 'I am an alcoholic.'"
>
> He said, "That's part of the program. It comes from the central offices... And the patients have to let us know that they are alcoholics. What would you do?"
>
> I told them I would take the whole thing off. I would put in "I am a human being." Human beings got no alcoholic, he is this pure spirit. And you've got to do it. When you tell these people I am a human being, they will become a human being to overcome the alcoholism. (Four Worlds 1992, pp.15-16.)

There is a grave risk in **not** pushing into other spheres in the Empowerment Holosphere. Our experiences of empowering/empowerment (for our clients/ourselves) at the interpersonal and intragroup levels of society, levels where empowerment is experienced in a very **essential** way, may render us complacent to the more difficult processes of working politically to challenge structural power relations. Certainly, our bureaucratic places of practice often support such a complacency. One can see this is the attention being given to concepts such as self-esteem, social networks and social support. Improved self- esteem, social support and self-help may be promoted as solutions to long-standing health inequities, as immediately empowering experiences that nonetheless may mask political motivations to reduce social service or health service expenditures.

Offe (1984) has created a sophisticated theoretical framework to explain the contrary role of the state in advanced capitalist societies. At its simplest, the theory holds that the state must buffer the social inequities caused by market economies under conditions of monopolistic capitalism, without revealing that this is what it is doing. To reveal this as its work would be to further the "legitimacy crises" that arise from contradictions internal to capitalist economies and from tensions between an unfettered market capitalism and those external (state) regulations that are increasingly required to maintain the social conditions under which market capitalism might continue. Offe contends that the state does **not** exist merely for the accumulation of capital, but also for its own sake. The "crisis of crises management" confronting the pluralistic state system is that it simultaneously requires capital generated by its flanking economic system, and legitimacy generated by its flanking social normative (civil society) system, though the logic of both systems (commodifying and non-commodifying, respectively) are in contradiction.

Relative to health promotion policy and program issues, Offe's theoretical framework suggests that the state must find ways of framing (naming) health problems that arise from social inequities in such a way that the more basic cause of these inequities (monopolistic capital accumulation through market economies) is obscured. Self-esteem, self-help and social support offer such a problem-framing, since they construct psychosocial health problems embedded in the monopolistic accumulation of capital through market economies, without referring to this embeddedness. As explanations, they de-contextualize and de-historicize the experience of oppression.

There are two immediate implications of Offe's critique upon our practice. First, a bridge between the intra- and interpersonal aspects of social support (self-help, self-efficacy, self-esteem) and the community social change potential of social support (organizing, advocacy, healthy public policy) needs to be constructed. Second, we must spend more time critically thinking about the concept of "needs," and whose claiming of needs or issues we should use in our work. (Fraser 1989) A good example of the "needs" problematic can be found in the gradual erosion of the claim of violence against women (in which the phenomenon of male spouses physically or psychologically "assaulting" women was related to multiple forms of male privilege through a critique of patriarchy and male power) to programs for "domestic violence." Whose need-naming leads us most towards more equitable social relations? What need-naming buries challenges to base power inequities? What are the implications of adopting one need-naming, over another?

Community Organization

Community organization describes the process of organizing people around problems or issues that are larger than group members' own immediate concerns.[4] Community organization implies choice on the part of professionals and their agencies or departments over **which** communities to work with. Not all communities necessarily **should** be supported to accrue more power. Polluters, for example, could be considered a community. A residents' association betraying its ignorance or prejudice by attempting to prevent a group home or affordable housing from being established in its neighbourhood is also a community. Some communities exhibit their own internal coherence and power by being highly intolerant, even violent, towards all others who are not part of that community. While there is no true consensus within the health sector on which community groups warrant support, there is growing acceptance of an advocacy framework of action, explicitly recognizing that priority community groups are those whose income, educational, occupational and general social class positioning places them low within the hierarchy of political and economic power. (Watt and Rodmell 1988)

While community organizing may strive for inclusivity in community-building, for agreement amongst as broad a collection of community groups as possible, relatively powerless groups usually seek to correct their imbalance by limiting the power other groups have over them. These groups only create their group-identity as a "community" in **opposition to** or **conflict with** those groups that are more powerful than themselves. This dynamic has been at the base of all Alinsky-style organizing efforts, the confrontational "we/they" approach to organizing which has been used successfully to create community groups from the seemingly intractable conditions of isolation and apathy. (Ward 1987) This dynamic is also what underlies the first axiom of community development programming: Start where the community group is at, their problem, their definition, their understandings.

But now I want to move dialectically to this first axiom's antithesis, not to deny its importance but to enrich our understanding of its practice. Should we not also be integrating within this first axiom of community development some aspects of where health professionals are at, our knowledge, our definition, our understandings? Community development/organizing is not about top of the mind problem-namings, the public-opinion polling choices that we are told are accurate to within 5 percentage points 19 times out of 20. (Accurate in what respect? In reflecting what are people's uncritical top of the mind opinions?) Community development/organizing is (or should be) about hard thinking and questioning **together**, sharing ourselves in our communities over "thought-aches" in which all persons agree to respect each other's contributions and differing starting frames of reference.

An example of where muddled thinking about problem-naming could lead was offered in many major North American cities a few years ago. If you had asked any reasonably poor person in any state-housing complex what their leading health problem was, they probably would have answered, "drugs." The "drug problem" had been rediscovered, the complex political and sociological reasons for which lie beyond the scope of this Chapter's intent. Whether or not drug abuse had factually grown in size over past years, it was there in front-page headlines, soap operas, on radio phone-ins, television talk-shows and documentaries that purported to tell only the truth. Relatively powerless groups share in common with relatively powerful groups (and especially with politicians) the capacity to have their reality named by mass media. So the number one health problem of poor neighbourhoods at the time was "drugs."

If you had accepted that top of the mind definition in community development first axiomatic fashion, where would it have led to? More police, more social marketing programs, more drug education courses, perhaps more drug rehabilitation programs, and lots of anti-drug posters and pamphlets.

But what if you instead had asked the "community" such questions as:

> Do you take drugs? (No! Think I'm gonna tell you that?)
>
> Do your children take drugs? (Well...Maybe, I'm not sure really...I hope not, at least not the hard stuff...)
>
> So what is the drug problem anyway? (Hmmm. Fear of safety. Pushers. No lights at night. Lots of unemployed kids, nothing to do, little to hope for. While we're at it, slum landlords, never get anything done with the repairs. Oh, and more cops hanging around now, and we tend to be black and they tend to be white and you know what that means. And crummy welfare policies, always hassling over money, any wonder some of the kids take to drugs, or take to dealing? etc. etc.)

The "drug" problem can be constructed in a number of different frames, each with an entirely different set of possible activities that may develop. Moreover, the renaming/reframing of the drug problem produces concerns that are more specific, more topical and more directly pertaining to power-relational issues amongst the groups in question (e.g. racist police practices, landlord violations, physical building repairs, welfare reforms). Workshop participants referred to these renamed, reframed issues as "generative themes," by which was meant problem-namings that immediately allow some connection between personal experiences of threat or disempowerment, experiences which Kieffer (1984) maintain form the precipitating step in a personal empowerment process, and "structural" (organizational, institutional, political, economic) conditions of threat or disempowerment. I speculate that a given community grouping or geographic locality may have a limited repertoire of such themes, and that an important element in an empowering health promotion practice is facilitation of a "discovery" of these themes. The critical dialogue of power-with relations is one in which all parties engage in a search for the generative theme, a search in which epidemiological data on disease and health behaviours, the conventional language of health agencies, become only two of many pathways to meaning.

One important way to consider the practice implications of community organizing is to distinguish in meaning two words frequently employed interchangeably in describing community group/institutional relations: "involvement" and "participation." Their dictionary meanings are quite revealing: involve means to "wrap (a thing in another) wind spirally, entangle (person, thing, in difficulties, mystery, etc.); implicate (person in charge, in crime, etc.)...make complicated in thought or form" whereas participate means to "have a share, take part (in thing, with person); have something of...entitling to share...taking part." The essential and significant difference between involvement and participation is the moment when others (individuals, groups) are invited to join in the problem-posing, problem-solving process. (See Table 12; these differences bear on the dynamics of authentic partnerships discussed under the political action sphere.) Involvement invites others after the problem has been named in quite specific ways; participation invites others to name problems in the specific ways most useful to the largest number. Involvement, like community-based programming, is often a useful and healthful action; the conundrum arises when the problem-naming (language, frames of reference) of the institution does not cohere with that of the community group and the latter attempts to respond on the terms set by the expert, becoming "involved" in (wrapped up in, made more complicated by) these terms. Certainly, an institutional demand for constant participation can be just as disempowering as involvement masquerading as participation. It may represent a wasteful expenditure of citizen time, and excuse the failure of politicians to make difficult policy decisions. But, at present, few of our health promotion actions are genuinely participatory, with its twin implications of "joining in" by right, and for purposes of sharing.

We also need to consider what it is we are asking community groups to participate in, as the following story makes clear:

> A health education coordinator, in the name of health promotion, received permission from her managers to convene a committee on housing and health with activists from housing rights groups. These groups wanted safer, better heated and ventilated, and more affordable housing. The health educator, agreeing politically with their concern and knowing that violence, dampness and poverty were "real" health issues, desired her unit to be more relevant to the issues expressed by these community groups.
>
> The housing and health committee met for a year, documenting with studies and literature reviews that the activists' concerns were legitimate. Recommendations were drafted and the health educator felt much better about her occupational role. The report was presented to her manager, who agreed with the literature review and with the studies, but nayed most of the recommendations as "too radical." The report went back to the committee. The recommendations were rewritten, watered down. This time the health educator's manager passed the report along, but **his** manager, while agreeing with the literature review and with the studies, nayed most of the watered down recommendations as "too radical."
>
> The report went back to the committee, which now suffered the absenteeism of many of the housing group activists. The recommendations were rewritten again

Table 12:
Fundamental Characteristics of Participation, Involvement and Consultation

PARTICIPATION	INVOLVEMENT
• open frame of "problem-naming"	• problem determined by agency sponsor
• shared decision-making authority	• structure is advisory; it may have some, but very limited, decision-making autonomy
• full stakeholder identification; the problematic of stakeholder legitimacy is central to the process	• the problematic of stakeholder legitimacy is not central to the process
• negotiated, formalized relationships	• there is a tendency to non-formalized agreements, or to formalized conditions of involvement unilaterally set by the agency sponsor
• resources for stakeholder participation ("levelling the playing field")	• terms of engagement are ultimately in control of the agency sponsor
• stakeholder accountability to a larger constituency (the group or organization they represent, other groups or organizations in their problem domain).	• citizens treated as individuals rather than as organized constituencies

CONSULTATION

- information from citizens sought on specific plans or projects
- little or no enduring structures for ongoing engagement between agency sponsors and its publics

> in the deft style of "public health parenthood," platitudes "full of sound and fury but signifying nothing." (Everyone's against poverty; not everyone is against those economic structures that maintain the wealthy who create the poor.) This time the report made it all the way to City Council, where it was discussed for 90 seconds and unanimously passed, a victory for the health educator and her managers. But by this time the original committee was completely moribund, and the health educator was puzzling over what had gone wrong.

The mistake here was confusing participation in a **bureaucratic** process with participation in a **social change** process. Bureaucratic processes are inherently conservatizing, and the higher one goes in complex organizations the greater is the imperative to ensure that controversy is avoided, rather than created. With good intention, the health educator had wanted to engage in an activity that made everyone feel better about themselves, including her own desire to be relevant or useful in a larger project linking health with social justice. Instead, the question she should have been asking herself is "What activities are best suited to the end: Effecting political change in housing policy?" This requires a recognition that her organizational requirements for change differ from those for community groups and, particularly, for activist leaders within those groups.

This recognition would not deny her and her staff an important role in achieving the end, but would reconstruct it using a metaphor of a nutcracker, with the nut being the specific policy-issue at hand (e.g. safe, healthy, affordable housing). Persons within the organization, in their role as legitimating professionals, provide the studies, creating a strong inner arm. Activist groups outside the organization provide the stories and, in their more powerful role as citizens, posit the more politicized demands, and at the appropriate political level (e.g. City Council). Their concerns, buttressed by the concurrent internal validation made in the language of the organization, give those empowered as decision-makers (politicians) less opportunity to refer the issue inwards for "more study," risking the conservatism illustrated by the story; the policy nut begins to crack. (This is not to suggest that the nutcracker is the only means of creating social change!)

The acid test of citizen participation in our programs should not necessarily be that of complete "citizen control," as Arnstein (1969) argued in her classic "Ladder of Citizen Participation." The acid test should be the egality and empathy – the intentional effort to create equity – in the relationships between citizens, community groups, professionals and service organizations. If we accept this, then we can also move beyond the simplistic criteria for success in community development: Self-sufficiency of the community. It is often tacitly assumed that good community development leads to a time when the community (the group) becomes wholly sufficient in its own internal resources, no longer dependent upon the community workers, the agency or the state. Dependency does pose problems, both in terms of the group retaining autonomy over its agenda, and in terms of the agency and its workers being able to support efficiently a number of different groups. But community self-sufficiency may be a myth.

Some of these points become clearer in a re-framing of Susan Rifkin's influential evaluation model for participation in community development. This model allows project mapping along five axes (needs assessment, leadership, organization, resource mobilization and management), using three broad rankings of participation (narrow, medium and broad). (Bjaras, Haglund and Rifkin 1991) (Table 13) However, the ranking scale would define as "better" ("broader") many of the definitional elements of community development critiqued above. A modified version of the same Table would recast the relationships differently. (Table 14)

Table 13:
Ranking Scale for Process Indicators of Community Participation

	DEGREE OF PARTICIPATION		
Indicators	**Narrow (1)**	**Medium (2)**	**Wide (3)**
Needs assessment	Professionals decide	Professionals and community define needs together	"Community" asks for programme
Leadership	Represents a small group of people	Combination of groups' interests -- small and large groups	Represents many groups' interests
Organization	Rigid purpose, run by one or few organizations, run by professionals	In between	Flexibility in meeting goals. Includes non-professionals
Resource mobilization	No contribution from beneficiaries (only official funds)	In between	Beneficiaries provide the major contribution
Management	"External" professionals make all the decisions	Joint decisions by professionals and community	"Community" makes the decisions using professionals as resources

Table 14:
Ranking Scale for Process Indicators of Community Participation

Indicators	DEGREE OF PARTICIPATION Professionally Dominated (1)	Locality Dominated (2)	Negotiated Equity (3)
Needs assessment	Professionals decide	"Community" asks for programme	Professionals and community define needs together
Leadership	Represents a small elite group of people	Democratic but closed membership	Democratic and shows clarity on who it represents, and why
Organization	Rigid purpose, run by one or few organizations, run by professionals	Goals wholly determined by groups	Flexibility in meeting goals. Includes non-professionals
Resource mobilization	No contribution from beneficiaries (only official funds)	Beneficiaries provide the major contribution	Beneficiaries clear on the nature of their contribution, and their ability to negotiate for required resources
Management	"External" professionals make all the decisions	Community makes all the decisions	Joint decisions by professionals and community on areas where they overlap; and a process to manage separate decision-making where there is no overlap. (Strategic consensus; and effective management of dissensus)

Because of the centrality of "community" to health promotion – the **Ottawa Charter** uses the term repeatedly and many commentators regard community as the venue for, if not the very definition of, the new health promotion practice (Green and Raeburn 1988) – I will close discussion of this sphere with some reflective comments on this vital concept. Community must always be treated as a problematic, something embedded in multiple levels of meaning, rather than as a structure or an object in which solutions might be found or actions (programs) created. The multiplicity of phrases workshop participants used to describe their own experiences of community (Table 3, Chapter 2) resembles the many meanings commentators and social theorists give to the word "community" itself. The brief discussion of community-based and community development programming already illustrated the difficulties we encounter in clarifying what is, in effect, the most important concept of our professional work.

When community is defined bureaucratically it tends to be given geographic (locality) or demographic attributes: community as housing project, community as neighbourhood, community as municipality; or the "poor community," the "women's community," the "aging community," the "disabled community," the community of this or that ethnoculture. Geographic definitions of community define peoples' informal and formal interrelationships by political jurisdictions; demographic definitions of community define these interrelationships by how statistical data are collected. This may be useful administratively, but it also may have little to do with how people actually structure their social relationships, their own experiences of community. If nothing more, daily mobility (work/home) and communications technology renders a locality-based definition of community limited, at best. (Poster 1990; Roberts 1979; Pinker 1982)

When the phrase, "**the** community" is used, it mystifies the nature of intergroup and interorganizational relations within complex societies, which includes conflict and dissensus as well as cooperation and consensus. The totalizing "the," for some, represents a desire to find another privileged social actor of change to take the place of the theoretically and empirically challenged marxist concept of the proletariat. The totalizing "the," for others, represents a politically reactionary romanticization in which the "concept of community becomes sanctified, attributed with qualities it does not possess, and treated as the remedy for problems which originated in the inadequacy of community provision of welfare" (Pinker 1982). This abuse of the term, in which **the** community is presumed to embody the capacities, problem-solving potential and human caring that are often missing from our bureaucratic, political, and intergroup organizational styles, must stop. Each time the term community is used, the term's users must clarify who they are talking about, under what circumstances, for what purposes, and over what duration in time.

There is a more generous interpretation of our use of **the** (totalized) community. It may represent a buried spirituality, a shorthand for more profound, communautarian ideals. The etymological root of community, "the quality of sharing and caring," is wonderfully evocative of recent speculation that the three universal precepts of most religions – caring, service to others, and generosity – are not simply necessary for community survival; they also stimulate the immune system, and improve the chances of our own individual survival. (Ornstein and Sobel 1987) Our health may be "hardwired" to our experience of community. But while this idealized notion of community has an important purpose in some aspects of our work, especially in the collaboration process described under the political action sphere, it is notoriously vague as a guide to whom we mean when we invoke it. If we are going to use "the community" as an abstraction or spiritual/moral statement, let us say so. If not, the point of specifying who, why and when we mean in using the term still stands.

Another major problematic persists in the romantic casting of community-as-locality. This notion of community, with its fully decentralized decision-making, may allow for programs unique to community groups and their perceived needs. But it can also, and in a politically reactionary way, mystify the reality that most economic and social policy is national and transnational in nature. Local decision-making can only be within narrow parameters at best, and is unlikely to include substantial control over economic resources. As Brown (1989) recently commented "Small may be beautiful, but it may also be insignificant." A similar point is made by Daly and Cobb (1989) in reference to environmental economics: Political decision-making must remain at the level at which economic decision-making occurs, otherwise public policy, those decisions embodying community ethics, will devolve to private economic interests.

Community is equally the beloved of neomarxists, who would claim the need for more democratic control of all social resources by the "community," and of neoliberals, who would devolve responsibility for all social services to the "community" level and preach grassroots participation in the name of empowerment and democracy. While the former may be too simple a rendering of intergroup dynamics, the latter is invidious for its use of responsibility as a euphemism for blame. We might distinguish authority from blame as follows: Authority is responsibility **and** the resources required to fulfill that responsibility. Blame is responsibility without the resources. We must exercise particular caution that our support for community groups, our community development and organizing work, does not become an unintended buttress to political and public policy actions based upon economic theories that would see power continue to accumulate to the few by being usurped from the many.

If nothing else, the political limitations of geographic community (community-as-locality) cautions us that, unless we append a strong advocacy component for macro-level policy changes to our drive for decentralized decision-making, we may again unwittingly privatize by rendering local what are much broader issues. We need to ground our actions in the lives of our community groups, but we must give these actions flight to the distant political reaches that determine whether whole towns or cities will even live, or die.

Coalition Building and Advocacy

Coalition building and advocacy are tonics to the limitations of community organizing. Coalitions are groups of groups with a shared goal and some awareness that "united we stand, divided we fall;" advocacy means "taking a position on an issue," initiating actions in a deliberate attempt to influence private and public policy choices. The two are linked in the Holosphere because advocacy usually involves coalitions.

There are two differing facets of advocacy. First, professionals themselves can increase the strength of their own political voices, taking positions on such broad healthy public policy issues as social welfare reform, housing needs or affordability, employment policies, environmental standards or any other concerns that may be expressed by individual clients or by community groups of clients. Second, professionals can aid community groups in their own advocacy by offering knowledge, analytical skills, information on how the political and bureaucratic structures function and so on. Their support for advocacy is an extension of their support for community organizing. This begs the question of organizational comfort with advocacy, specifically the organization's own efforts to define which community groups it feels it can work with; and the extent to which its own policies empower its staff to work in resourceful, non-controlling ways with those groups.

Health organizations can also support advocacy by creating those policy documents and analyses that form the policy nutcracker's inner arm, thereby legitimizing the advocacy concerns of those community groups with which they work. Institutions play a powerful role in shaping and defining what is important in social reality (and consequently political discourse) through the implicit and explicit statements made by the types of services they offer, and the policies they create and make public. One of the important functions organizations can play in advocacy is endorsing or commenting upon the public policy concerns of less powerful groups.

Coalitions can be chimeric creatures, assuming different shapes and meanings. It is important to distinguish between institution-created coalitions and community group coalitions. Usually, institution-created coalitions are an extension of community-based programming, and reflect the desire to improve interorganizational coordination of services, to avoid service duplication and to better integrate services, for both humanistic and cost-efficiency reasons. (Goering and Rogers, 1986) This type of coalition or coordinating function is important insofar as it may lead to better resource provision in the personal care and small group development spheres. Rarely are such organizational coalitions concerned explicitly with structures of social power. Community group coalitions are more concerned with power-over issues (that is, with socioenvironmental risk conditions) and are an extension of community organizing. The dynamics of these two levels of coalitions will likely differ, and if the second subsumes the first it risks imposing a community-based model upon a community development process.

Because coalitions often represent a direct politicization of an issue, member groups have to learn to set aside both the complexities of their concerns, and the differences in priorities and political analyses that often exist between them. Specifically, as important as conflict is in developing a given community identity, at some point community groups must move through conflict to consensus if they are to develop a sufficient social base to significantly influence and alter public policies and political decision-making. I have witnessed this from the inside-out when, almost twenty years ago as a tenant in Vancouver's Kitsilano neighbourhood, I was an active community member of an Alinsky-style effort to create a tenant's union. Parallel efforts also existed in the skid-road area and at the provincial level. Offers by these groups to form a coalition, however, were spurned and publicly criticized in the "we/they" process of creating our own community identity. While this gave our group a sense of our own potency, our empowerment was ultimately short-lived and restricted to a steadily shrinking elite. We had failed to deal with the process of sharing power with other groups and so, inevitably, we failed to deal with the powerlessness of tenants within our own neighbourhood.

Coalitions are known for making odd bedfellows, reflecting the strategic truism that it is easier to form a coalition around a simple issue than around a complex one. To an extent, coalitions also represent a return to empowerment at the small group level, since it will be necessary for the **individual** representatives of member groups to learn how to share power amongst themselves and to support each other in achieving the specified goal or goals of the coalition. One of the limitations of many coalitions is that they fail to undergo a process of exploring power and consensus amongst themselves in their goal-driven pursuit of the immediate issue.

The policy advocacy potential of organizations of professionals, rather than organizations employing professionals, is particularly untapped. This potential could extend to yet a third type of coalition, that of professional/associational groups speaking with the nominal voices of authority. An organized political voice of caring professionals may be crucial in moving us towards more just and sustainable forms of social organization: It is we who see the human costs of current economic and political practice, we who have access to the knowledge and information on how the governing system works, and we who have a degree of professional credibility in our statements. Empowerment for professionals, then, is both recognizing and claiming the power we already hold, not "over" others, but in relation to how governments and economic elites currently enact programs and policies.

In Ontario, public health has established itself as an important, legitimating voice in policy debates. When the Ontario Public Health Association (OPHA) argued a few years ago that welfare reforms were an essential investment in health, the Association helped to influence all party support for the reforms. As professional advocates, the OPHA met the institutions on their own terms. It gave them studies; it gave them data;

it debated in the polysyllabic language of policy; it called upon the best its epidemiologists and policy analysts could offer. But the OPHA was not alone.

Victor Sidel, a past-president of the American Public Health Association, once wrote that, "Statistics are people with the tears washed off." Institutions react to statistics, people respond to tears; politicians and bureaucrats are also people. So the OPHA worked with coalitions of church groups, anti-poverty groups, unions, newly forged organizations of the poor themselves. There were stories. There were tears. There were people behind the numbers, and an incredible power that came in recognizing and honouring the differing but mutually supporting roles of community activists and professional advocates, the power of the nutcracker.

It is important that, in our professional role, we assume a more political stance on issues affecting the health and well-being of those communities we serve. But we must also distinguish between **advocacy with** and **advocacy for**. The latter form of advocacy, frequently employed by front-line workers when they encounter clients frustrated by bureaucratic problems with public housing, welfare or immigration, represents the weight of professional status applied on behalf of a less powerful person. Like empathic case-work (the personally empowering band-aid) this "advocacy for" may relieve a crisis but not necessarily leave the person better equipped to deal with the next problem. "Advocacy with" implies that, even as professionals voice their own positions on issues affecting their clients, they support their clients, be they individuals or groups, in exercising their own voices.

Political Action

Political action represents an intensification of actions initiated under the rubric of coalition advocacy. Such action may be partisan or non-partisan, local or national, participatory or representative in democratic form, legally enacted or civilly disobedient. The line between what comprises coalition advocacy and what constitutes political action is fuzzy; one important difference may lie in the role played by organizations and groups loosely considered to be representative of social movements. A coalition or alliance of groups coalesces action around a particular issue that cuts across differing commonwealths of values; a social movement brings its commonwealth of values to multiple issues. To assimilate without coopting this commonwealth of values – a premise upon which this monograph's rendering of health promotion and empowerment is based – we must allow ourselves to be scrutinized by these movements.

We must also build authentic partnerships with those who stoke the engines of social change. One vehicle through which these partnerships might be built, one idea which draws together the politics of the private, public and voluntary sectors at the local level, is the growing Healthy Cities movement. Over 800 communities are part of this network. There are two problems for which the Healthy Cities idea might prove particularly useful:

1. Creating structures for meaningful citizen participation in local decision-making, where none exist, and
2. Creating a vision around which the different sectors of government bureacuracy might talk through their redundancies and their rivalries.

The power of the Healthy Cities idea, with its emphasis on ecological sustainability and social justice, lies in its potential to become one of those visions around which conflicting community voices might begin to unite. This point brings me to a consideration of what may comprise a shift in Western polity, a profound transformation in our social institutions that is not about **what** we do, but about **how** we do it, a shift or transformation illustrated in the literal explosion of intersectoral fora.[5] What distinguishes these fora from past consultative bodies, or from short-term advisory committees, is their relative endurance, a degree of autonomy from normal government decision-making processes, a deliberate "search for meaning" involving value-based goal definitions, and participation by a broader range of stakeholders, including groups or sectors representing the more formally organized elements of social movements.

Most of our current processes for social change (excepting violent revolutions) are reified or closed. Politicians are bound by partisan pressures, short electoral time-horizons, extreme and highly public demands and the headlines of each day's morning papers. Bureaucracies are bound by institutional inertia and an implicit/explicit rule to maintain a status quo, though it is mistaken to consider the byzantine corridors of bureaucracy to be monolithic or ideologically singular. This conservatizing of bureaucratic discourse (planning, policy, programming) is often disparaged, yet constancy is not wrong to pursue or unnecessary to human societies. It is simply insufficient to architect or lead the changes we know we must make. Interest groups, extra-parliamentary organizations of change, are usually bound by limited and limiting frames of reference, their specific ways of defining and looking at reality, at relationships, at problems. They become dependent upon narrowly scoped issues. Academic institutions are bound by a relative distance from the coal-faces of governance, direct services and economic production. Policy think-tanks are bound by often being fronts for partisan political frames of reference. Most existing public consultative approaches are bound by mistaking, intentionally or not, "involve" for "participate," initiating consultation only after the problem has been named, and hence the frames of reference and range of potential actions already implicitly selected and delimiting.

That intergroup conflict is both healthy and perhaps essential to social change should not lead us to shun the necessity of uniting diverse, conflicting groups at some higher level of community. Community-as-ideal, the moral or spiritual resonance of the word, is what gives it both its power and its appeal. As Gardner (1991) expressed, pluralism without commitment to the common good is pluralism gone beserk. Pragmatically, the community born in conflict or struggle rarely survives the eventual peace "unless those involved create the institutional arrangements and non-crisis bonding experiences that carry them through the year-in-year-out tests of community functioning." (Gardner 1991, p.14)

Gray (1989) provides a comprehensive collaboration model for promoting those functions. Successful intergroup collaboration, which she defines as "a mutual search for information and solutions," has five features which characterize the process-as-outcome. (Table 15) There are also several steps in effective collaborating, first and most important being problem-setting. This requires a "common definition of the problem," a "commitment to collaborate" and "identification of the stakeholders." This stage subsumes a pre-negotiation stage, the goal of which is arriving at a common definition of problem and intent broad enough to get stakeholders to the table. Effective collaborating requires the efforts of persons Gray labels "midwives," the community developers of organizations-as-communities. These midwives (functionally distant from all of the stakeholders) work with the stakeholders **before** they come to the table, seeking to find the "superordinate goal" that Sherif (1966) years ago argued was the basis for initiating any reduction in intergroup conflict. This goal must be "compelling for the groups involved, but...unattainable by [any] one group, singly; hence it is not identical with "common goal"...[it must also] supersede all other goals each group may have." (Sherif 1966 p. 88) Finding this superordinate goal is not a simple task though, as I suggested earlier, the power of the Healthy Cities idea may be precisely its function as a superordinate goal; provided, of course, that it does not in the process colonize other superordinate goals emanating from other sectors, such as the "livable city," "safe city," "sustainable city" conceptual initiatives.

Table 15: Successful Collaboration

1. Enhanced recognition of stakeholder interdependence.
2. Differences are dealt with constructively.
3. Joint ownership of decisions is developed.
4. Stakeholders assume collective reponsibility for "managing the problem domain" through formal and informal agreements.
5. The process is accepted as continually emergent.

Source: Gray, 1989.

This condensed discussion of collaboration theory may be difficult to digest. The following case-story (a fiction built upon a composite of real situations presented in the workshops) provides an illustrative spoonful of sugar. The story concerns an attempt to establish a collaborative environmental forum in an industrial suburb I will call Pitchfork.

Pitchfork suffered from citizen perceptions of poor water quality and pollution-related diseases. Two community groups had formed although both groups were waning: One because its leader had moved, another because its leader became ill. A public health association, intrigued by the concept of Round Tables on Environment and Economy, approached Pitchfork's local council, the industry and the two community groups and urged them to develop a joint partnership to reduce water pollution and improve environmental health (their superordinate goals). Eight months later, community group participation on the collaborative committee was moribund, the committee appeared to function more as apologist to industry than as a true collaborative forum and no action was occurring on water pollution levels. The committee, claiming industry-acting-in-good-faith, was not even calling for release of industry data on toxic emission levels.

There are many ways one might construe this failure in collaboration, but there are a few important ones.

First, in the absence of strong community groups, the consensus-oriented collaborative forum became the reference group for the environmental representatives. This reduced conflict between industry and the community groups as the different stakeholders sought to be "nice" to each other. But this niceness may be shortlived, since conflict reduction relied on a folding of the environmental groups' interests into the "niceness" interests of industry and local council, and not on any genuine reduction in the conditions that lead initially to the conflict.

Second, the collaborative forum's meetings occurred over socializing events (dinners, recreational activities) that built interpersonal bonds but failed to emphasize group interdependency.

Third, past struggles between industry and environmentalists in Pitchfork had been insufficient for the two community groups to create a strong identity for themselves, or to establish themselves as legitimate stakeholders. In the absence of this strong identity, citizens sitting on the collaborative committee became absorbed within the more powerful identity of industry representatives.

Fourth, members of the collaborative committee were recruited as **citizens** and not as **organizational representatives**. The collaborative committee could not be truly collaborative; no formal intergroup agreements could exist because participants were not collaborating as group representatives.

Fifth, no midwife had been present in the collaborative forum's birth, and no pre-negotiation stage for "problem-naming" had occurred.

Sixth, the condition of unilateral action by one of the stakeholders (industry) had not yet been removed through successful conflictual challenges by the environmental groups.

The public health association that sponsored this project is now attempting to locate (discretely) a few environmentalists within Pitchfork who would be willing to initiate a "challenge" to the legitimacy of the collaborative forum. This challenge would recommence the task of creating an environmental group identity separate from that of the "consensual tyranny" of the prematurely constituted collaborative committee.

The six lessons learned from this case-story might be considered prelimary terms for effective (authentic) partnership. Panet-Raymond (1992) frames these terms more specifically, based upon insights gleaned from the attempts to forge relations between community health and social service centres and neighbourhood volunteer centres in Quebec. Table 16 merges the two sets of conclusions. These terms are preliminary only. Nonetheless, they offer a starting point from which health agencies might push an empowering health promotion practice into a more mundane practice.

Table 16: Terms of Authentic Partnerships

1. All partners have established their own power and legitimacy. This often requires a period of conflict, and some enduring strain between powerful and powerless groups. Providing resources to these groups is one facet of community development work, provided such resources remain in the autonomous control of the groups.

2. All partners have well defined mission statements; they have a clear sense of their purpose and organizational goals.

3. All partners repect each other's organizational autonomy by finding that visionary goal that is larger than any one of their independent goals. This requires extensive "midwifing" work, to set the shared agenda. Achieving this shared agenda is another facet of community development work.

4. Community group partners are well rooted in the locality; they have a constituency to which they are accountable.

5. Institutional partners have a commitment to partnership approaches to work with community groups.

6. Clear objectives and expectations of the partners are developed. The partners create a commitment amongst themselves to jointly "manage the problem domain."

7. Written agreements are made clarifying objectives, responsibilities, means and norms; regular evaluation allows adjustments to these agreements.

8. Community workers have clear mandates to support community group partners without attempting to get them to "buy into" the institutional partner's mandate and goal. This distinguishes community development from community-based approaches to work.

9. All partners strive for and nurture the human qualities of open mindedness, patience, respect and sensitivity to the experiences of persons in all partnering organizations.

Endnotes

[1] The Empowerment Holosphere was originally constructed as a linear Continuum, with personal care at the left end, and political action at the right end. (Labonte 1990) This partly reflected the linear, causal thinking that is embedded in the dominant medical (conventional) approach to science, and in which most health professionals are steeped. But it also reflected workshop participants' desire to emphasize the community organizing, coalition building and advocacy, and political action continuum nodes, as these represented strategy areas then ignored, given lip service to or poorly understood by their employers.

[2] Bloor and McIntosh (1990) tell of instances when this is not the case, and the health "home visitor" is seen as a surveyor in the Foucaudian sense of inducing hegemonic power. In these instances, the authors interpret the lying or laconics (concealment) of the "clients" as a rudimentary form of empowering resistance. Burcher (1992), in a small study of public health nurse visits, notes more simply that many nurses move quickly into problem-solving and advice-giving behaviours, rather than empathic forms of listening and reflecting. This itself raises an interesting dialectic around professional practice: If the nurse listens empathically, but without an **a priori** awareness of initiating power differences between herself, her institution and her client, does she risk inviting more revelation from her "clients" that can then become part of the knowledge used by her institution to control problems arising from the base economic or patriarchal structures that give rise to her clients' problems or issues in the first place? Could the problem-solving and advice-giving behaviour, at least in the instance of an uncritical acceptance of initial power differences, have the paradoxical effect of creating a resisting wall of resentment and concealment (when the advice is not wanted or appears prying or patronizing) that permits the clients to retain a degree of autonomy? Ideally, one may strive for a power-critical, empathic practitioner; but empathy without power-critique, empathy as a **skill** rather than as a **commitment**, may serve more the interests of the powerful than the powerless.

[3] "Small" only partly refers to size. Primarily, this "functional" social level of the Holosphere model refers to groups that look primarily inwards, to the socioemotive needs of their members, i.e. support groups. Normally, these groups are small in number, and many group theories hold that beyond a certain number (over 20 or so) the task/status structuration that arises leads intractably to more formalized relationships. (Ridgeway, 1983)

[4] The terms, community organization and community development, are used somewhat interchangeably within this article. Community organizing more accurately might be described as the process of building new, outward looking community groups, and as such is one aspect of community development, which as a health department practice has been defined as "the process of supporting **community groups** in identifying their health issues, planning and acting upon their strategies for social action/social change, and gaining increased self-reliance and decision-making power as a result of their activities." (City of Toronto, 1993)

[5] In Ontario, Canada, examples of these fora would the Premier's Council on Health, Wellbeing and Social Justice, the Ontario Round Table on Environment and Economy, their municipal counterparts, a recently established provincial Land Use Commission, and several other government-supported intersectoral structures.

Conclusion

There is no real closure to the issues discussed in this monograph, but I will seek some completion to its voyage in two fashions: A story of the empowerment model, and some ruminations on organizational transformation. The two are obverse faces of the same coin, for the empowerment story, by being about life and people, is a modest story of organization. Yet it is the small work of ten thousand hands rather than the large labour of a single pair that manifests an empowering health promotion practice and builds healthier communities.

A few years ago, government plans to implement the welfare reform I referred to earlier were stalled due to their costs, sparking the creation of a massive coalition of welfare advocates, organizations, professionals, church and labour groups. A Toronto health centre joined in the fray. This centre was a small neighbourhood organization, providing primary health care, health education and promotion, community organizing and other supporting services, all managed by an elected Board of neighbourhood residents. The neighbourhood had a high ratio of single mothers on welfare. Many of these women came to the centre for their medical services because the primary care team spent time with them, listening to their concerns about money, counselling them on their stresses and strains, hearing their loneliness, and applying the band-aids when they were needed.

But these services were not enough. The primary care teams knew that these women's health problems were less rooted in their bodies, and even in their health behaviours, than in the structured inadequacies of the welfare system. These teams, with the centre's health educator, created small groups on health exploration for these women that offered a supportive learning experience, breaking through some of the isolation and "learned helplessness" engendered by poverty. Some of the women, with the support of the health promoter, organized a community action group which, on its own and in coalitions with other organizations, lobbied for reform. The primary care teams also took case stories of these women's lives. These stories wove a tapestry with the studies collected by the health administrators in a powerful policy statement advocated by the Board. Centre staff, through their professional associations, lobbied senior government bodies, issued press releases, and joined with coalitions advocating reform. Board members met with politicians, met with media, addressed protesting rallies, made deputations before committees and linked with "social movement" groups in their effort to locate the reforms within a larger social justice agenda.

I cannot say that the reform issue has been resolved in a province with mounting deficits and unemployment. An empowering health promotion practice is as much a process as it is a product. But what I can say is that one notable outcome of this linkage of strategies was that it honoured the capacities of all persons in creating healthy change. At no other time in the centre's history had there been such joy, such commitment, such a lack of internal squabbling and such a clarity of purpose, as when the centre participated in a health project where every staff member saw their role and played it, and where the project was so much bigger than themselves.

As Saul Alinsky once opined about community organizing: One does not pursue happiness; happiness is the pursuit. The same may be said for the "grappling" towards more empowering forms of health promotion practice

It seems self-evident that this pursuit must also pay attention to the dynamics of organizational behaviour. As organizations increase in size and complexity, there is a greater tendency towards more rigidly hierarchical structures. Hospitals exemplify this phenomenon within the health sector. With few exceptions, hospital health promotion efforts are confined to patient education (often patient **compliance**) programs or lifestyle behaviour programs. (Squyres 1985) Public health units are usually smaller in size and, being somewhat freer of the medical model, are in an arguably better position than hospitals to champion an empowering health promotion practice. Size in this instance, though, may affect this potential in both directions. Smaller health units may have flatter organizational structures and offer more professional autonomy. At the same time, a smaller staff may also be more confined to mandatory program delivery, with larger urban health departments having more organizational "slack" to elaborate upon an empowering health promotion practice.

Community health centres (CHCs) and centres locaux de services communautaires (CLSCs) in Quebec appear to offer the greatest potential for an empowering health promotion practice, embodying as they do all three approaches to health enhancement (medical, behavioural and socioenvironmental), relatively small geographic catchements, multiple entry points for "consumer"/community group participation and decision-making, and the use of multidisciplinary teams rather than solo/single-profession providers. Some commentators on Quebec CLSCs, however, argue that this empowering potential has been coopted by the state (Lamoureux et al 1989; Panet-Raymond 1987), and ongoing health care reforms in that province preclude any simple judgements of CLSCs' abilities to support or engage in actions spanning the Empowerment Holosphere. Similarly, Ontario is rapidly expanding its community health centre program, raising concerns that such centres are becoming "mini-institutions" rather than more activist-minded community organizations.

In broad terms, one might expect an empowering health service organization to reflect all, or some, of the following structural characteristics:

- Services are provided to people who continue to reside in a neighbourhood context, as opposed to an institutional context.
- The service actively engages in helping people maintain their independence and autonomy.
- The service actively addresses a person's physical, mental and social wellbeing. It encompass primary care, disease prevention and health promotion models, that is, the service integrates the medical, behavioural and socioenvironmental approaches to health.
- The service allows multiple entry points for "consumer"/community group participation and decision-making, including an elected board with a majority from persons living within the locality catchement area. However, the service would be cautious and recognize that such formalized participation represents its culture, and may not represent the culture of participation favoured by the community groups it serves.
- The requirement of community group sponsors, that is, the service exists not because centralized planners deem it more cost-efficient but because local residents wish to "sponsor" it. This is a problematic notion for some health service/promotion models, and on two counts. First, government fundors may well "sell" the concept and provide start-up funds to locality groups interested in service issues, much as what now occurs with Ontario community health centres. For the service to remain responsive to locality issues and political power relations, however, it must contain elements of being a community organization (autonomous control over its future, its policy, its services, its actions), and assume accounting responsibility only for those services and actions for which it engages in contractual relations with fundors. Second, it must retain this autonomy under conditions where some rationalization in services needs to occur to prevent wasteful expenditures in administration costs and inefficiencies in service overlaps leading to agency competition for the same clients.
- A statement of organization size, that is, beyond a certain staff/user size the elements of local citizen management and participatory democracy within the service agency (meaning the ability of users to negotiate to have their specific needs and interests met) may become untenable.
- Horizontal intersectoralism, that is, the use of multidisciplinary teams rather than solo/single-profession providers.
- Vertical intersectoralism, that is, there are good negotiated interorganizational

relations with providers of secondary and tertiary health care (specialists, hospitals), long-term care facilities, and other social service providers.

(adapted from Neufeldt 1987; and Canadian Council on Social Development 1986.)

The above listing is an extremely cursory overview of the structural/organizational considerations that face professionals wishing to work in an empowering way. At base are the questions: Are bureaucratic organizations inherently disempowering? Is there an unavoidable tendency for large institutions to grow larger, and to colonize the life-world of people with their mean, categorical paradigms of inquiry and management?

These are not answerable questions. They are only grappling questions. They require our grappling, and urgently so. Our institutions and our professions are not likely to cease and desist, though their particular make-up may show some seasonal variations. Our institutions and our professions must therefore transform their public relations from power over to power with. In this process, we must eschew our sedimented organizational tendency to look for "hardware" changes: Changes in policy, in organizational structure, in the structural mechanics of who reports to whom on what, how often and why. We need to break free of the paradigm of "organizational change" (in which we see change as something that happens from time to time to our organizational hardware) and adopt a paradigm of "organizational development" (in which change is recognized as incessant, and the most important issue is one of developing our "software," the quality of the relationships between those persons for whom the workplace is one of their major experiences of "community"). As with community development, this organizational development must be intentional. It must be supported from the top of the hierarchy, but it cannot be top-down. It must emanate from grass-roots, but it cannot simply be bottom-up, replacing one group of elites with another. It must be resourced. Community development requires a lot of hard, intentional person-power work by the community development worker. The same is true for organizational development. Organizational development must also flourish at the margins, the places within organizations where quasi-autonomous forms of innovation are tolerated. Finally, the organizational developer, like the community developer, occupies an ambivalent place: Part of the organization but not of it, functionally distant from the "hardware" status structures of the organization.

This monograph has attempted to provide some ideas for how this organizational development might be done, with particular respect to the health sector and its new mantle of a new health promotion. I realize that a new dialectic for grappling also emerges: Effectively balancing the energies devoted to developing the organization-as-community, with the energies required to serve in an emancipatory way those individuals and groups who are our communities of interest.

The issue we face is not new. It seems entwined with much of human history. It also evokes a story, a lesson I learned years ago from my grandfather and which seems a suitable momentary closure.

An immigrant from the farmlands of the Ukraine, my grandfather always grew gardens without pesticides or fertilizers, using intensive organic techniques and companion planting long before they were discovered by magazine editors and trendy book publishers. He grew a lot of cabbages, so many cabbages that one day I asked him,

"Grospapa, you can't possibly eat all the borscht you might make from these cabbages. And your freezer is too small to freeze the ones you don't make soup with. Why do you grow so many?"

He shrugged and looked to the sky. There were many clouds gathering because in Vancouver, British Columbia, where he had settled, there are only two kinds of weather: Either it's raining, or it is about to. This creates an ideal ecosystem for those shelless gastropod mollusks better known as slugs, which are infamous for their palate for leafy vegetables.

"We make a deal," he answered, gently kicking one of the slimy creatures with the toe of his shoe. "They eat half the cabbages, and leave the other half for me."

Dedicated to Hermann Grospapa Epp, who died peacefully on March 2, 1993. He lived a long, sometimes difficult and always caring life, and taught me the lessons of respect and reciprocity.

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Glossary

This monograph stipulates definitions for a number of terms and concepts that have varied meanings within public health. These stipulated meanings are not categorical – I do not know which ones work best for which situations – but because some of the meanings may differ from other usages, my meanings are reproduced in this glossary. The monograph also uses a number of terms from social theory and philosophy. Several of these terms are also included in this glossary.

The words in this glossary are not arranged alphabetically, but conceptually; they appear more or less in the order in which they figured in the unfolding of the monograph.

Health is a resource for living...a positive concept...the extent to which an individual or group is able to realize aspirations, to satisfy needs, and to change or cope with the environment. (World Health Organization, 1984) As such, health is a subjectively evaluated state, synonymous with well-being and on a continuum with illness. It interpenetrates, but is separate from, the experience of disease.

Disease prevention is any activity or program designed to prevent disease, disease being some deviation from physico-chemical normality upon which there is some professional medical consensus. There are three levels of disease prevention.

> *Primary prevention* describes programs or actions aimed at helping people grow up with, or maintain, healthy behaviours.
>
> *Secondary prevention* describes programs or actions aimed at helping people change unhealthy behaviours.
>
> *Tertiary prevention* describes disease treatments which prevent a person from becoming more ill, or from dying; or for programs or actions aimed at preventing a serious disease from arising due to less than optimal physical functioning.

Health promotion is any activity or program designed to improve social and environmental living conditions such that people's experience of well-being is increased.

A *medical approach to health* is concerned with returning sick people to a disease-free state, that is, it focuses on physiological risk factors.

A *behavioural approach to health* is concerned with promoting healthy lifestyles in order to keep people in a disease-free state, that is, it focuses on behavioural risk factors.

A *socioenvironmental approach to health* is concerned with creating healthy living conditions, that is, it focuses on psychosocial risk factors and socioenvironmental risk conditions.

Physiological risk factors are those physiologically-defined characteristics that are precursors or risk factors to disease. Examples of these risk factors include hypertension, hypercholesterolaemia, genetic predispositions, diabetes and obesity.

Behavioural risk factors are lifestyle behaviours associated with an increased risk of disease, e.g., smoking, lack of activity, high fat diet.

Psychosocial risk factors describe complex and multidimensional psychological experiences that arise through one's social circumstances, e.g., lack of social support, low self-esteem, high self-blame, anxiety, low perceived power.

Socioenvironmental risk conditions are social and environmental living conditions known to affect health status, and over which persons have little or no individual control. These conditions can be altered through group or community choices or actions, with supporting changes in public policy. Socioenvironmental risk conditions include low socioeconomic status (income, education, occupation), dangerous or stressful work, pollution, discrimination, low political or economic power, large gaps in income/power within a community, region or nation.

Healthy public policy describes a process in which the impact upon health of actions falling outside of the health care sector (in areas such as housing, environmental protection, welfare, energy, agriculture) is politically recognized, such that these other sectors begin to take greater accounting of how their policies affect health.

Phenomenology describes knowledge constructed from the lived experiences of each individual, without regard for the distinction between objective and subjective conditions.

Ontology is what we believe about the nature of reality.

Epistemology is what we believe about the relationship between reality and how it is observed, the relationship between the knower and the known, or what it is we can know.

Methodology is what we believe should be the process of inquiring into the nature of reality. Methods are the tools we use, but are not the same as methodology, which is our beliefs about why some tools are better than others.

Paradigm is a term popularized by Thomas Kuhn. It refers to the self-enclosed ways in which scientists construct the very phenomena they study, through the types of questions they pose, what they consider to be appropriate answers, the theories they use to formulate their questions, and so on. A paradigm is similar to a world view, or ontological position, because it incorporates beliefs about the nature of reality. There are three broadly different paradigms of scientific inquiry, the **conventional** (the natural science method, often associated with quantitative methods), the **constructivist** (one of the social science methods, often associated with qualitative methods) and the **critical** (another social science method, often associated with participatory action methods).

Social support refers both to one's social networks (family, friends, groups, organizations, and so on) and to the emotional, material and companionship support they offer. Social support enhances health through both a direct or main effect (people are healthier because they have social support) and a stress-buffering effect (social support reduces the physiological stress reaction to social stressors). Social networks predict health as far as a direct or main effect is concerned; people who have familial, interpersonal and community networks have less disease than those who do not.

Hegemonic power refers to the ability of a dominant group to control the actions or behaviours of others. Hegemonic power is that form of power-over that is invisible, internalized, structured within the very nature of our day-to-day living so that we come to take it for granted. This internalization is sometimes also referred to as false consciousness, learned helplessness or surplus powerlessness.

Empowerment is the capacity of choice. It includes the ability to define, analyze and act upon problems one experiences in relation to others, and in one's social and environmental living conditions. Empowerment as a process describes the means through which internal feelings of powerlessness (hegemonic power) are transformed, and group actions initiated to change the physical and social living conditions that create or reinforce inequalities in power.

Self-esteem is a concept used to describe a person's appraisal of their capacity and self-worth that has some reasonable basis in "fact," which means that their appraisal is partly derived from what others think of their capacity and self-worth. Self-esteem is a tricky concept, because it is often used in non-relational ways, implying that our sense of self derives solely from within, or it is regarded as a skill that can somehow be taught and managed. It is both of these things, and much more.

Self-efficacy is a belief in one's personal capacity to act to make changes. Self-efficacy requires a belief that personal action will make a difference (high internal locus of control), and that the change is valued (high outcome-expectation). Only the combination of high outcome expectation, high self-efficacy and high internal locus of control is consistently associated with sustained health behaviour change. High outcome expectation and low self-efficacy reflects the "surplus" powerlessness in Lerner's construct, and its "self-blame" dimension. Personal change is desired, but the individual does not believe in a personal capacity to change. Personal helplessness is different from universal helplessness, which combines low outcome expectation and low self-efficacy. The person feels incapable of personal change, but also believes that personal actions won't make much of a difference. Universal helplessness may reflect "true" powerlessness, i.e. it may be a realistic appraisal of one's relative lack of social, economic and political power or resources. When health workers fail to take these sociopolitical realities into account, they may unwittingly create personal helplessness by encouraging a high outcome expectation among individuals who, on their own, are unlikely to achieve that expectation. While self-efficacy makes theoretical and intuitive sense as a marker of psychosocial health, self-efficacy measures seem to work best when directed to very specific behaviours. In other words, there may be no single, generalizeable attribute called self-efficacy. (see Strecher etal, 1986)

Self-help vs. community groups A distinction is sometimes made between self-help and community groups on the basis of direct suffering: Self-help groups buffer direct suffering, community groups look to sufferings' antecedents. Self-help groups are often small in number, and focus primarily on the socioemotive needs of their members. Community groups vary in membership and degree of formalized organization, and focus primarily on external resource and power issues. Both types of groups are nurtured in an empowering health promotion practice.

Community organizing is the process of creating new **community groups**. This may or may not require a stage when the groups are more self-help (inward) than community (outward) looking.

Community development as a health department practice has been defined as "the process of supporting **community groups** in identifying their health issues, planning and acting upon their strategies for social action/social change, and gaining increased self-reliance and decision-making power as a result of their activities." (City of Toronto, 1993)

Community is a complex concept. Generally, a community can be said to exist when a group of persons have a shared identity as being group members, and a sense of collective purpose. The group may or may not be based in the same locality. Most persons belong to multiple communities; most local neighbourhoods or towns have multiple communities within them. Community is also sometimes used to express an ideal, a spiritual quality based upon notion of common good or communality. These different levels of meaning should not be confused by health professionals or their agencies in their day to day use of the concept.

Community-based programming is the process of health professionals and/or health agencies defining the health problem, developing strategies to remedy the problem, involving local community members and groups to assist in solving the problem, working to transfer major responsibility for on-going program to local community members and groups.

Community development programming is the process of supporting community groups in their identification of important concerns and issues, and in their ability to plan and implement strategies to mitigate their concerns and resolve their issues.