

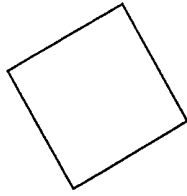
whom I work possess of them. They are infinite in scope because they describe our communicative relations with others, freed of any material base. An empowering approach to health promotion involves both types of power in each and every action. Indeed, I believe that each relationship is constituted by both types of power, the former residing in the control over the material base and political and economic structures of our social lives, the latter search for meaning amongst one another. A health promotion practice that paid attention only to the former, to changing zero-sum power relations, risks the proverbial change of rulers that is the joy of fools. A health promotion practice that paid attention only to the latter would fall short of achieving any systemic change.

EMPOWERING RELATIONS (EXERCISE 2)

Choose someone you work with. In your working roles (e.g. health promoter, manager, program supervisor, policy maker, researcher), describe a situation where you used your power transformatively, to create a power-with. Consider the following questions:

- What types of power-over did you think you had?
- How did you use it transformatively?
- What happened when you used it this way?
- What did the experience teach you about power relations in your work?

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- ¹ Few of us probably realize that the origin of the English term, "wealth," meant an individual's spiritual wellbeing alongside the collective wellbeing of entire communities. The ability of mass media images and dominant ideologies to distort these aspects of collectivism and caring are both subtle and insidious. During the 1996 Olympic Games, a popular advertisement run during Australian television coverage of the Games equated athletic competition with airline performance. The ad comprised a slow camera shot of various athletic devices (running shoes, javelin, pole vault) with the caption (and I paraphrase somewhat) "Being the best is not just about having the best equipment..." The camera pans upwards to a new jet. "It's about people, and their spirit of competition..." the camera cuts to an image inside the airplane, showing what we are told is "the spirit of competition." What we are actually seeing is a flight attendant giving particular attention to the needs of an adult travelling with a young child. This is an act of social caring, yet it seems to be denied by its equation with individual competition.
- ² IV drug users in large cities for years were "hard to reach" for health agencies. They became tremendously easy to reach when agencies began providing free needle exchanges—something immediately relevant to and useful in the lives of IV drug users. Out of this exchange some trust can develop. When IV drug users reach a stage when they wish to change their lives (something that occurs for many of them) there is a trusted infrastructure to which they can turn for assistance.
- ³ These examples are drawn largely from a two year action research project with health staff from the Toronto Department of Public Health (Labonte 1996c).



CHAPTER 4:

Participation in Health Promotion: The 'Hardware' and the 'Software'

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INTRODUCTION

Why is public participation in health promotion important? How does one support this participation, particularly in health promotion policy-making, recalling that policy decisions are essential both to “make healthy choices (lifestyles) the easy choices” and to remedy unhealthy risk conditions?

There is a large literature on the benefits of public participation in day to day health and other public service programs that help to answer the first question. Susan Rifkin (1986), writing on community participation in health programs, for example, cites these benefits as:

- a more educated public
- more relevant program actions
- improved service delivery
- mobilisation of “untapped” resources of community members in service delivery, and
- gaining professional entry into larger social justice issues.

Reviews of public participation in environmental health concerns attest to such political benefits as:

- improved planning and decision-making by proponents
- increased decision-makers' accountability, and
- demonstration of government commitment to public consultation (Environment Ontario 1991).

Others, writing more on public participation in local governance and program services as a social development strategy, claim participation “is itself a value,” and forms both a goal of social policy, and the process of developing such policy (Doyle, Mitchell and Orr 1990, p.12).

Among the cited benefits of participation:

- a more cohesive community
- enhanced dignity and worth of individual citizens
- more effective use of citizens' knowledge, skills and experiences
- better programs, and program decision-making
- greater public acceptance of programs, and program decisions.



From a health promotion vantage, then, public participation directly improves the health and wellbeing of many people by overcoming their isolation and perceived powerlessness, two psychosocial risk factors for illness (see Chapter Two). Participation can help to mobilise community actions on issues that are more relevant to people's lives, and can lead to improved policy decisions affecting the deeper determinants of health (risk conditions). Finally, public participation provides the building base for a "whole of governance" approach to solving problems, in which key stakeholders involved in an issue work across their boundaries, self-interests and power differences to resolve the problem.

But this raises a series of questions important for health promotion leaders. What does participation look like? What are the hallmarks of good participatory structures, good participatory principles? Who should participate, and when in the decision-making process? And what is it exactly that we would like the public to participate in?

DISTINGUISHING PARTICIPATION FROM OTHER INSTITUTIONAL/ COMMUNITY RELATIONS

Participation, as a concept and practice, defies any fixed definition (Sadler 1978, Rifkin 1986). Rather, it is a process that continuously changes and unfolds as individual actors (and their varying group or organisational constituencies) negotiate the terms of their relationships. This imprecision in meaning can vex bureaucratic planners in their desire for neat, administrative categories (Adorno 1957), and it is not surprising to see many government manuals on public participation rationalising participation into a series of steps, or a template of strategies (e.g. PRAXIS 1988, Environment Ontario 1989). Such an exercise is not "wrong." The steps constitute some of the participation "hardware" that will be returned to shortly. But unless these steps and strategies are seen as malleable suggestions they risk becoming procedural rules, restricting the ability of the government organisation or agency sponsor to negotiate changes with its differing publics. It is the ethical integrity and communicative competency, the "software" of participation, that ultimately determines how effectively governments, institutions and community groups can work together on health determinants.

In simpler terms, participation is a concept that describes the attempts to bring different stakeholders together around problem-posing, problem-solving and decision-making. Without participation, there can be no partnerships. But it is important to distinguish participation from other forms of relations between governments, institutions and communities, for a great deal of tokenism (public involvement without authority) characterises participation in program and policy work.

Sherry Arnstein (1969) developed a now classic “Ladder of Citizen Participation” to describe some of the differences in these government, institution and community relations. Arnstein’s ladder consists of eight rungs, the upper six of which are most salient to a discussion of public participation. The top three rungs represent “degrees of citizen power,” and in descending order are:

1. Citizen Control Community organisations have direct management and financial control (hence decision-making control) over project.
2. Delegated Power Citizens occupy the majority of seats on a decision-making committee; or their organisations are contracted to undertake a particular part of a project.
3. Partnerships Citizens are active on a decision-making body but don’t hold the majority; however, there is real negotiation between citizens and other committee members. Once the committee groundrules are established, they cannot be unilaterally changed. Finally, citizens on the decision-making body are answerable to a community constituency (organisation or association) separate from the decision-making body on which they sit.

Arnstein describes her next three rungs as “degrees of tokenism:”

4. Placation Citizens on decision-making bodies are treated as tokens; their participation does not stem from a clear commitment to broader citizen participation. Citizens usually lack an external constituency to which they are answerable, and they are not provided with the resources to play a significant role in actual decision-making.
5. Consultation Citizens’ opinions are constantly sought, but only within the terms of those surveying for these opinions. There is no mechanism for their participation beyond telling officials what they think.
6. Informing Citizens are informed of a project or program; the agenda is controlled by the project staff.

Arnstein’s regards her last two rungs (manipulation and therapy) as “nonparticipation.” While manipulation implies deceit, therapy has many connotations besides the placatory role she accords it. Indeed, if one moves beyond the mechanics of actual participation structures, to participation as a value in itself, one must immediately deal with the complex reasons why most relatively powerless individuals fail either to demand participation, or to engage in it when the structures are there (Kasperson 1978, Labonte 1990). Often, there is a psychology of apathy, or learned helplessness, as discussed in Chapter Two.

Certainly, we should drop manipulation from consideration, because it is unethical. But I would also argue that we drop community control as the epitome of "true" participation (as health promoters often claim it to be), because such control is both unlikely and undesirable. When we define health promotion as partnership or relationship-building, we can begin to refine, if not critique, the notion of "community control" and its more contemporary visage of "devolution" or "de-centralised decision-making." The notion of community control is already suspect, since it begs the questions: Which community? And control over what? For years, community control was tokenistic, stopping shy of decision-making authority over resource allocation. Now, at least in Canada, Australia and Aotearoa/New Zealand, those countries with which I am most familiar, this decision-making authority includes resource allocation with some honest efforts to ensure that the decision-making body is not stacked simply by self-interested professionals. But there is no real authority in this devolution, because decision-making responsibility does not extend to control over those public policies that govern resource generation, and therein lies the rub. Nor am I arguing that these devolved bodies should have such control, for, by logical extension, that would only hasten the balkanisation of the nation state into smaller units even less able to offer any regulatory check against global capital, and which may well act in less democratic fashion than the larger state they supplant.

In defining health promotion as a process of creating more equitable relationships amongst groups and institutions, we can also bury the myth of community self-sufficiency. Self-sufficiency means that the community group is able to mobilise and/or provide its own resources and skills to enable it to function fully autonomous from others. This is often assumed to be the goal of community development and, by extension, empowering health promotion work, or as a measure of maximum community participation (Bjaras, Haglund and Rifkin 1991). However, the health sector's rhetorical acceptance of such terms as partnerships and intersectoralism should lead practitioners and their agencies to foster equitable and effective interdependencies, rather than to promote the autonomy of localities. Self-reliance, as a contrasting concept and as staff with the Toronto health department defined it, means that "the community group is able to negotiate the terms of its interdependence with external professionals, organisations and institutions" (Toronto Department of Public Health 1994). It is probably dangerous to the internal autonomy of the community group for it to become wholly dependent upon any one professional, organisation or institution for its resources. The community group should also have sufficient lay or non-paid members to retain some independence of agencies. But the goal of health promotion work is not community self-sufficiency; it is the ability of those community groups with whom we partner to negotiate their own terms of relationship with those institutions (agencies) that support it.

Decentralising decision-making over public programs does allow for programs and actions unique to community groups and their perceived needs. (But again, which groups and which needs?) The concept, however, must be tempered with recognition 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 one of the policy analysts with the Worldwatch Institute noted, small is beautiful, but it may also be insignificant (Durning 1989). Health promoters, whose work is often at the important group-building micro-level of our social fabric, must append a strong advocacy component for macro-level policy changes at senior government levels to their drive for decentralised decision-making. Otherwise, they may subtly “privatise” by rendering strictly local the choices available to citizens, mystifying the actual exercise of political power by national and transnational economic elites.

The rhetoric of decentralised local control may also inadvertently support growing social inequities by failing to defend social programs against fiscal restraint or regressive tax reform by more senior government levels (Labonte 1995). Part of the appeal of “community,” especially to neoliberal and neoconservative political parties, is that it can readily justify dramatic social service cutbacks in the name of increasing community control. It is instructive that, in many countries, decentralised community decision-making in health care is only becoming a fact as public funding for health care is shrinking, hospitals are closing and thousands of health care workers are losing their jobs.

So, having eliminated both manipulation and community control as participatory ideals, we can distinguish more clearly between three words often jumbled together to mean the same thing: consultation, involvement and participation. Consultation is straightforward: We ask, but do not dialogue. Involve and participate are more complex. 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.”

Participate means to:

“have 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. 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. This is sometimes the case when communities are asked to

become “involved” in health coalitions where the outcomes (e.g. CVD or cancer rates) have already been defined by the health agency, often accompanied by epidemiological data and arguments that use concepts and language foreign to citizens’ day-to-day experiences. At the same time, 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.

For public participation also carries opportunity costs (time, energy) and may not even represent how citizens wish to engage with institutions and professionals (see Table 1).

Table 1: Fundamental Characteristics of Participation, Involvement and Consultation

PARTICIPATION:

- negotiated, formalised relationships
- open frame of "problem-naming"
- shared decision-making authority
- full stakeholder identification
- resources for stakeholder participation ("levelling the playing field")
- stakeholder accountability to a larger constituency (the group they represent)

INVOLVEMENT:

- citizens treated as individuals rather than as organised constituencies
- terms of engagement are ultimately in control of the agency sponsor
- structure is advisory; it may have some, but very limited, decision-making autonomy
- tendency to non-formalised agreements in which agency sponsor retains more invisible power

CONSULTATION:

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

Consider an account of an “empowerment” project that attempted to establish an alternative school and that, according to its architects, failed because parents and students did not “seize” control over school decision-making (Rappaport 1987). Teachers retained control, “often with the complicity of the students and their parents.” But why should we care that parents and students fail to seize the reins of power offered to them? Perhaps the offer was all the power they needed, representing evidence of a good partnership with teachers and officials who listened, cared and in whom they could trust. It may well be that accepting the decision-making power offered to them would be a disempowering burden, rather than the reverse. Public participation should not mean transforming citizens into volunteer bureaucrats.

THE 'HARDWARE'/'SOFTWARE' METAPHORS

In 1993/94, I was involved in a research project for the Equity and Access Committee of the Ontario Premier's Council on Health, Wellbeing and Social Justice (Labonte and Edwards 1995). The Council, since disbanded by a conservative government, was an intersectoral "think tank" attempting to formulate policy to address the determinants of health. One of the concerns the Council wished to address was "equity," improving access to services by those in most need, and developing more empowering relations with these groups to influence policies governing deeper health determinants. (A great deal of mythology shrouds policy, policy analysis and those high priests of senior government corridors who speak its particularly arcane dialect. The facts of policy are quite simple: Policy states the rules by which institutions make decisions about the social distribution of wealth, status and authority.)

Thirty-one locality projects were identified, selected in part to represent different sizes and types of sponsoring organisations, different groups, different issues and different provincial regions. Services could be part of these projects (and frequently were), but they had to be regarded by project staff and participants as enablers to some larger form of social/collective action, and not as ends in themselves. Our interest in these projects was not about how they delivered services; it was how these services "served" people in these projects in ways that allowed them to address social determinants of health, partly through involvement in local and provincial policy decision-making.

Locality projects were not only asked how they might better participate in local and provincial policy decision-making. They were also asked how they enhanced participation by the groups they worked with in their own internal decision-making processes. Their learnings can be categorised according to "hardware" and "software" approaches, terms used by project workers themselves.

Hardware approaches are primarily concerned with the formal structures or procedures in which decision-making occur. They are like the potential power of a computer hard drive. Other metaphors that capture this facet of participation include "structure" or "procedures" (the formal organisational lines of authority and decision-making, the policies and procedures governing decision-making boundaries and methods, and the allocation of resources to maintain the decision-making body).

Software approaches are primarily concerned with the nature of the relationships between people in the decision-making moment. They are like the programs that computer hardware runs. Other metaphors that capture this facet of participation include "process" or "norms" (the informal communicative patterns between people, the degree of ethical or ideological compatibility between members of the decision-making body, the attention paid to the feelings and emotions of lived experience, as Elizabeth Reid argued, must become part of our policy and program decisions).

Table 2: Hardware Approaches to Participation

- focus on formal structures or procedures
- the potential power of a computer hard drive
- specific policies on participation structures/committees
- resource supports for public participation, e.g. childcare, transportation, training, technical advice
- guidelines for historically underrepresented, e.g. a certain number of women, ethnoracial minorities, persons with disabilities, poor groups
- policy on style of decision-making (consensus, majority)
- role of committees: advisory, joint decision-making, authoritative
- clear goals and objectives of reason for participation, e.g. how broad or narrow is the range of issues for decision-making, how clear is the structure of authority, what is the content of partnership agreements (if any)
- good participation hardware deals with the redistribution of zero-sum power-over, by making more equitable who has authority, status and, as a result of the decision-making, resources

Table 3: Software Approaches to Participation

- focus on the nature of the relationships between people
- the programs that computer hardware runs
- group norms of behaviour
- exercises to build listening and respect
- awareness of power differences between members and groups
- community developing approach to historically underrepresented
- good participation software deals with the creation of non zero-sum power-with

Often, larger organisations or institutions become preoccupied with decision-making hardware, seeking procedural changes that presumably would make decision-making more participatory. Smaller, locality projects often give greater emphasis to software approaches, stressing the necessity of respectful, consensual relationships “around the table.” Both approaches are necessary and interdependent. A good software program requires hardware to “run;” good hardware without any software is merely potential, but not actual, “empowerment.” Hardware processes information; but it is only in our software that we generate knowledge and wisdom.

PARTICIPATION HARDWARE/SOFTWARE (EXERCISE)

Most people have had participatory experiences that they consider good or bad. The following exercise can be used to initiate a reflection on these experiences, and so generate some criteria for effective participation.

In table groups, discuss from your work experience times when there was “good” participation. Identify those aspects of the hardware (organisational structure or culture, policies, committee structures, resources for participation and so on) that allowed the participation to be “good.” Identify those aspects of the software (interpersonal relationships, facilitation, individual commitment to the process and so on) that allowed the participation to be “good.” Note these on the prepared charts. Repeat the discussion for experiences when participation was “not so good.”

Select the most important aspects of hardware and software (good and bad). Circle these. Post the chart on the designated wall.

A synthesis of these key principles, based on the work of many groups and drawing from published experiences, is recorded in Table 4. These insights constitute one of the better summaries of good participatory practice; they are general enough to be useful in many contexts, specific enough to offer real guidance, and based upon the combined experiences of over 120 seasoned community workers and policy makers.