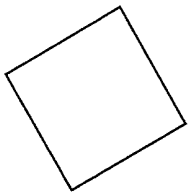

CHAPTER 1:

Power, Participation and Partnerships for Health Promotion

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Health promotion practice is about bringing about social change, about changing community norms, values and individual behaviour. It is about the synergistic interaction between individual and larger system change, be that larger system an organisation, a community, an economy, a political system or the intersection of a number of these or other systems.

Our understanding of how social change occurs is in itself changing. The emerging paradigm acknowledges that new ideas and practices grow out of practical experience, that how things are done may be as important as what is done, and that competing ideas can productively co-exist. Social change, and so development, is increasingly understood to be about human interactions, about the capacity and the will to change, about processes and programs rather than projects, complexity rather than simplicity. It is respectful of differences and wary of fragmentation. It fosters empowerment and responsibility rather than a predefined good.

The emerging paradigm raises a number of questions about the practice of health promotion. For example, whose reality counts? In the case of poverty, is it the reality of the few in positions of professional privilege or the complex, diverse, dynamic reality of those living lives of deprivations and ill-being? Professionals often define poverty in terms of per capita income and respond with strategies centred on economic growth. The poor themselves, however, may describe a more multi-dimensional deprivation, consisting of social inferiority, isolation, powerlessness, humiliation, seasonal vulnerability, ill health and physical disability as well as inadequate livelihoods.

As professionals and activists, we must accept that we cannot know what others experience and want. We have to ask. But the new paradigm further challenges the canons of professionalism. Unlike poverty, where the professionals are not themselves poor, health and well-being affect us all. As professionals and activists, we must therefore bring our own realities and aspirations into the analysis, set aside professional concerns of distance and objectivity, and understand from within ourselves. We must learn to learn from ourselves as well as from others.

The new paradigm also recognises that individuals, communities and nations have the capability and the will to act. This implies that the role of the professional is, for example, to ensure that women have all the information they need to make informed decisions about breast feeding in the specific settings of their lives. It is not to decide what is best for them. If we are struggling to change our practice of health promotion, from whom do we learn? A discipline-based practice, whatever the discipline, carves complex realities into specialisms and becomes a way of distancing one-self from the immediacy and messiness of reality. It also limits the sources of learning. For lessons can be learned from all who have tried, successfully or not, to bring about social change, and these insights must be drawn into health promotion practice.

How do we learn to recognise what we need to know and to know where we can find this knowledge? New developments in health promotion practice also raise questions about the purpose of technical assistance and funding in these areas. Should external support be used to achieve specific objectives defined in advance of the intervention or is its purpose to strengthen community's capacities to define their own objectives? If funding is about building peoples' capacity to act on their own choices, how can its effectiveness be measured? Ownership, relevance and need determine effectiveness and sustainability. How then can donor organisations evaluate processes of capacity building?

This emerging paradigm gives rise to a number of important questions:

- How can health promotion be a transformative practice?
- How, and from whom, does one learn how to answer that question?
- How can one give an account of knowledge, and of morality, that retains continuity with daily experience?
- What is the role of the professional, the outsider, in bringing about these transformations?
- How can transformative practices be monitored and evaluated?
- How can the experience of transformation be passed on and its energy sustained?

Answers to these questions will need to capture the dynamics of inclusion and exclusion, of domination and subordination, of thesis and antithesis, of self and other-centredness, and the ways these dynamics are played out in multiple and shifting settings, the ways they are influenced by desire, thwarted or strengthened by self esteem. They will also need to point towards the fault lines and pressure points through which social change can more easily occur and identify the means to trigger these changes.

Before turning to an account of how we are addressing these questions in our work on the HIV epidemic in developing countries, I would like to seek some inspiration from our own history in Australia. For we do not need to start from scratch to shape an answer to the question of how health promotion can be a transformative practice. We need only turn to our own recent past, for there are many practices from our history which can provide insights into and point the way to good health promotion practices.

I am going now to turn to the history of the women's liberation movement in Australia. For one of the sources of feminism's transformative impetus was this movement of the late sixties and seventies, a movement which had a highly developed theoretical framework, strategically linked to change. The women's liberation movement promoted some powerful practices for social transformation which, through a process of trivialisation and defamation, were discredited. Perhaps it is time to reclaim and reconsider them.

The first such conceptual and strategic practice was that of sisterhood. The concept of sisterhood was to apply to all women, no matter who they were or how different they were from oneself. All women were a part of the sisterhood. Women writing to women, including strangers, signed their letters "in sisterhood". Women referred to each other as "sister". The

concept of sisterhood responded directly to the lack of trust and the suspicion generated among women when they gain their identity and derive their value only from the men in their lives. In such societies, women become created as competitors and strangers without links to each other except through the patriarchy.

The relationship of women to the patriarchs provides a powerful metaphor for traditional practices of development and of the practice of health. Underlying or explicit to much practice has been a concept of development or health as vertical supplication, an analogue of client patron politics, of sinner-confessor or patient-doctor relationships, of the relation of colonised to the colonisers, of the have-nots to the haves, and of other vertical relationships of entreaty. Vertical relations of entreaty act against the creation of social trust and co-operation amongst supplicants, between the supplicants and the patron, and against the development of collective solutions. Cultures of domination undermine agency and the practices of interaction.

As a strategic tactic, the use of the concept of sisterhood did not directly challenge women's relations to the patriarchy. But it provided women with an alternative sense of identity and membership in a new and different world. Its use led to the recognition of diversity and the acceptance of difference amongst women. It promoted a sense of oneness in diversity and so contributed to the formation of trust and respect. It did not destroy women's vertical patriarchal, bureaucratic or political linkages but created new horizontal ones, directly woman to woman. Women began to think of women as "we" It made possible the emergence of a sense of solidarity, which is a precondition for collective action and social change.

The second tactical approach developed by the women's liberation movement was the valuing of the active participation in the movement of all interested women, no matter who they were. The voices of all women were to be listened to and the different realities these voices were expressing were to be thought about, reflected on and incorporated into the whole. It was acknowledged that some women are articulate and others not. It became important that awareness be created or rules introduced, that there be no domination by the articulate and no hegemony of their experiences and insights in the analysis. Often, in the women's liberation meeting, you might be handed five tokens when you enter the room. Each time you spoke you put a token in the centre and, once your tokens were finished you could not speak again until all tokens were in the centre. Procedures and practices of ensuring the hearing and the articulation of different perspectives were developed within the movement.

The theoretical basis for this technique was perhaps more intuitive, less articulated. But for women, the experience of being silenced was so common-place that there was a shared sensitivity to becoming themselves silencers. It was believed that the understanding of women's condition was dependant on all women being able to contribute, that there were significant differences as well as commonalities amongst women and that these, too, needed to be explored. The understanding of the whole required the perspectives and realities of all, not just the more articulate or powerful few.

In the valuing of all voices and in their third strategy, the creation of consciousness raising groups, the women's liberation movement was exploring a new and different approach to research methodology and theory construction. Women's stories, insights and life histories were being used to question classical canons of objectivity and subjectivity, to dismantle accepted notions of the public and the private, and to develop new analytical concepts to assist in understanding and elaborating issues around the quality and purpose of women's lives.

The approach was one of theorising through autobiography or through story telling. For many women, and to this day, the use of the personal pronoun "I" is difficult. For the women telling their stories, the confessional moments of sharing these stories were transformative, a stepping out of a self and a setting constructed by others, the start of a journey towards becoming who they are, towards allowing themselves to grow. Identity came to be perceived as capable of reconstruction, invention and change. The idea that people are inherently or essentially anything was challenged. For the listeners this symphony of voices was a way of understanding complexity and differences, for constructing a holistic understanding. It helped to put individual stories into context and thus made the construction of theory from voices a more systematic less idiosyncratic undertaking.

The third critical instrument of the women's liberation movement was the establishment of consciousness-raising groups: collective sharing of the unarticulated, the pain, the desire, the dreaming. Consciousness-raising groups were symbolic shelters and sanctuaries, spaces and sites where women could come together, talk and give each other support. They were the created analogues of wells and water taps, of river banks where clothes are washed, of sweat shops and factories, of hairdressing salons, of kitchens and school canteens and of all spaces where people talk. Consciousness-raising groups embodied in their very structures the way women in themselves relate to the world, not as individual and solitary selves but in connectedness with others. These groups rejected the accepted canons of objectivity to embrace the subjective and the empathetic. They were based on the premise that women could come to understand societies and their structures because of the lives that each woman had, not despite them. They brought the whole person into the process rather than insisting that a person could and should in some sense stand outside of their situation and critically assess it. Together women strove to give voice to and comprehend the reality of their lives from within the process of living them.

The creation of purposeful spaces, of sites of reflection and retreat may be one of most powerful of health promotion and development practices. For these spaces can be sites of healing and recovery, sites of resistance, sites of connecting across differences, sites of consensus building and collective problem solving, sites of creativity and exuberance. The greater the diversity of the group members, the more complex the analysis and the more extensive and inclusive the networks and the communities created.

Consciousness-raising made possible the emergence of a sense of empowerment. It became an expression of a collective will to change and itself a means of creating some of the required changes: self confidence, laughter, audacity, bravery. It created a space for tactical and strategic planning and provided a safe haven for forays into the world outside.

These practices of the women's liberation movement transformed the context of women's lives by transforming those lives directly, by making women themselves the agents of change. The forces of change flowed from within women to encompass all others who came within the orbit of their lives. These practices also created the trust, the respect and the networks of alliances across differences, which are the constitutive elements of social capital. They built communities of women and created the possibility of social change, the improvement of the lives of all through the improvement of the lives of women.

Social capital consists of the existence of trust, respect and the creation of alliances across differences. Where social capital exists or can be created, mutual aid societies spring into existence and credit training schemes, social investment funds and other such development initiatives are more effective. Where women trust each other and share a concern for the well-being of all, there, in those communities, one finds successful rotating credit schemes, communal mills, community banks, labour exchange, co-operative production, shared child minding, and the flow of information and advice which draw women into the world of political and economic participation. These are less effective or fail where there is a lack of trust and weak community norms of collective, rather than individual or familial, advancement. Social capital makes possible participatory development and good governance. It ensures that investment in human capital will be for the common good and not just for individual advancement. It ensures that investment in physical capital will be maintained, and used. It ensures that institutional development will address issues of nepotism, corruption, inefficiency and ineffectiveness. When people turn outward encompassing others and those who are different from themselves they become interested and active in improving the well-being of all. This we saw in the women's liberation movement.

Analyses which begin from the realities of women's daily lives create a textured and intricate understanding of what needs to be changed. However, strategic development—the development of strategies to address this understanding—which encompass only women will often just create safe havens or intermissions in a continuing context of disempowerment, discrimination or humiliation. For the quality of women's lives is determined not only by their own actions but by the attitudes and behaviours of husbands, children, mothers-in-law, employers, professionals, and public servants, and by the economic cultural and political values of their communities.

The same practices that women have used to create social capital could be used where-ever people are united in a desire for a different world, a different set of values, a different way of living. This site of shared desire, be it a concern about rising food prices, about women's right to make decisions about their bodies, about better access to education for children, or about keeping people from not becoming infected with HIV, could be the meeting place. Whenever

people are drawn together by a commonality of interest, they have created a space and a site for building community. The building of community requires that trust, understanding, respect and concern for others exist or be created amongst those coming together.

This sense of connectedness and the collective will to change are in fact the preconditions for a health promotion practice that is based on peoples' own dreams of the world they wish to live in. For social change must come from within, if it is to be sustainable, and all men and women need to participate. The fundamental challenge to health promotion practice is thus to facilitate and stimulate such preconditions and this, in turn, brings with it a changed role for the outsider, the health promotion practitioner. The outsider becomes the facilitator and the consensus builder. Empowerment, along with the confidence and hope that it creates, becomes a catalysing concept.

These women's practices point the way to the sort of practices which health promotion must incorporate if social capital is to be created and strengthened, that is, if trust is to be instilled and norms of individualism change to include concern for others. These practices will include ways to bring diverse people with different vested interests together to seek and reach collective solutions. Health promotion funding thus could include the funding of soccer clubs and choral societies, of guilds, chambers and poetry circles, mutual aid societies and trade unions, cafes and clubs. The more diverse the group that is bought together over a long time, the more extensive will be the partnerships and strategic alliances so formed.

All of these processes lead to rethinking health promotion as not only establishing conditions for health and well-being and institutions for good governance and service delivery, but also as a moral activity. At its centre is the improvement of people's well-being through, improving the quality of, ways of, and structures for human interaction. The vocabulary of social capital formation is an ethical vocabulary; trust, respect, concern, solidarity, dignity. Its practices will lead to a strengthening of moral practices including consensus building and collective decision making, rather than the disempowerment of directive or authoritarian dictums. The moral communities that form the core of health promotion evolve only in the context of such meaningful human relations and interactions.

For the practice of health promotion to be transformative, quite radical changes will be required. It can happen only if new social processes emerge in which:

- value is placed on people being able to come together, face to face, to act in myriad ways
- decisions are made as a result of compromise and consensus building between competing forces and not by force or authority
- discussion, doubt, imagination, reason and feeling, are all able to shape the outcome

- words, metaphors and images are not the instruments of state power, of religious or corporate interests, or of gender, class, patriarchal or ethnic privilege, but rather are expressions of desire and dreaming and instigators of change
- networks are extensive and inclusive and alliances and acquaintances stretch across differences; and
- emphasis is placed on the nature and quality of human interactions rather than on individual well being or advancement.

Thus, the transformative practice of health promotion would have to do with emotions and feelings, with doubt and vulnerability, with questioning and listening, with turning outwards and with human interaction. It would be grounded in a lived and conscious practice of interaction which is non-dominating. Resistance to domination has, in fact, to be learned and a collective will has to be created that will lead people to act and to change. For this to occur, there must be the spaces and occasions to come together, to pause, to reflect, to reconsider, to heal and so to create the possibility of transformation. How can this be brought about?

Let us now turn to an example drawn from the practice of health promotion and explore the ways the basic questions are being addressed in our work on the HIV epidemic. The United Nations Development Program (UNDP) along with all development organisations is itself struggling to understand how development co-operation can be a transformative experience, how it can put into practice an inclusive, process oriented approach to sustainable human development. This approach, we know, is characterised by relations of partnerships, by shared reflection on lived experiences, by the strengthening of people's understanding and capacity to act and by collective development of effective strategies which cannot be pre-determined but which arise from the lives of those who develop them.

In a recent paper entitled "Poverty and Livelihoods: Whose Reality Counts?" Robert Chambers argues that, if the most valuable expertise in both understanding reality and knowing what changes are needed is the expertise which arises from lived experience, then this presents major challenges to development practitioners. "If poor people's realities are to come first, development professionals have to be sensitive, to decentralise and to empower, enabling poor people to conduct their own analysis and to express their multiple priorities." Such an approach, he notes, will not be easy for the practitioner: "The challenges are paradigmatic; to reverse the normal view, to upend perspectives, to see things the other way around, to soften and flatten hierarchies, to adopt downwards accountability to change behaviours, attitudes and beliefs, and to identify and implement a new agenda. In sum, to define and embrace a new professionalism."

In our work we have been trying to bring these new practices of development to bear on the response to the epidemic. We have worked closely with The World Health Organisation (WHO) and the newly established joint United Nations program on HIV/AIDS, (UNAIDS) for the epidemic affects and is affected by a broad range of human endeavour including economic growth, redistribution policies, governance, health and social welfare policies, education, training and employment policies defence and law enforcement to name but a few.

The acknowledged imperatives of HIV practice are that:

- the epidemic demands an urgent and effective response for, indeed, in many places, human survival and national survival is coming to be an issue;
- governments, health and development professionals and other agents of change are facing a different and highly complex phenomenon;
- new knowledge and programming approaches are needed to respond to this multi-sectoral and multi-dimensional epidemic.

The approach that has been adopted by the program recognises that the most effective responses must grow out of lived experience. It is based on strengthening people's capacity to act on their own decisions and strategies through the development of partnerships and strategic alliances.

The approach adopted has been an interactive and iterative approach. Its expressed aim is to ensure that, in each area of program focus, there is a critical mass of informed, engaged and committed people working together within a supportive milieu towards an effective response. The nature of the interactive processes between these partners and the programs is intended to assist all those involved, including our own staff, in understanding the epidemic differently, acting differently in our personal lives, as well as our professional lives, and interacting differently with others in the various context within which we are responding to the epidemic. Consequently, this approach is itself in a constant state of development with frequent use of ongoing processes of innovation, reflection and review.

The strands of the approach can be drawn out into the following:

- the particular and continually deepening and changing understanding of the epidemic, its determinants and consequences, which the staff and partners bring to their work. This understanding is drawn from extensive experience as development practitioners and from living and working within the shadows of the epidemic itself.
- an approach based on capacity building. Such an approach can initially be defined by negation. It is not an approach wherein the program does what it considers needs to be done, nor is it a funding or grant program, funding proposals submitted by others, nor is it directive, telling others what needs to be done, although there is a place for all of these approaches both in development and in the response to the epidemic. Rather the program tries to bring its individual and collective expertise into processes of interacting which strengthen the values, processes, skills and behaviours upon which an effective response to the epidemic must be based.

- the nature of the relationships amongst all concerned, is perhaps best characterised as partnerships. Martin Buber once said that we cannot choose whether we will relate to life, only how. The relation of partnership recognises and respects the commitment and expertise that each partner brings to the work, accepts the importance of building consensus across difference, is based on a set of ethical guiding principles and requires trust and respect amongst all concerned. Working in partnership requires that attention be given to the choice of partners based on a set of principles, for example, gender sensitivity, the involvement of those affected by the epidemic, support to agents of change and community based organisations, the involvement of government and other actors. The choice of partners must also be based on motivation and vision. Partnerships require an ongoing process of clarification of purpose and determination of an agreement on the modus operandi of the relationships. In our work we have learned two very interesting things about establishing partnerships. It has been easier for us to enter into partnerships of equals with people who are infected by HIV and their organisations than with others. Those who have become active as HIV infected or affected people, have gained a sense of confidence and self esteem, which is essential for partnerships. The second thing we have learned is that there will be times, and have been times, when we have or others have, walked away from a partnership. Not all comings together will result in a relationship of partnership being established.

- the continual grounding of understanding and of the approach, the checking of these against the realities of the epidemic and of the lives of those struggling to respond. In particular, this involves actively seeking and listening to the reflections and experiences of our partners and following the developments in understanding and practice of individuals with whom we may not be working closely but whom we respect.

We ourselves have experienced these interactive processes as transformative of our own lives. They have led to changes in our understanding, in our ways of acting and in our ways of being, changes which continually enrich and make more complex our analysis and practice. We take these changes back into our relationships, both personal and professional, with others, and so we change the nature of those relationships and so this transformation flows on.

It is inherent in this approach that the outcomes of these interactive and iterative processes with our partners cannot be predetermined. Nor can that of subsequent interactions of our partners with others. Although the program may feel that certain things are important and can bring that analysis, those beliefs, or that knowledge into the interactive processes, what is decided to be done, how it is decided to do it, what agreement is reached, what beliefs people come to hold, will be determined by the nature of the processes themselves.

We have tried through this approach to address our substantive areas of program focus. We have done this through the creation, with others, of spaces and occasions in which the involved, diverse social actors can pass through individual introspection and collective reflection, to the strengthening of understanding. That is a process of drawing on what ones self has learned and of collective reflection to create a "thick" description, and out of that thick and complex

description drawing out those key elements which will provide the entry points for change or the bases for strategies for action. A "thick" description, as formulated by Denzin, does more than record what is happening.

> "A thick description goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self feelings. It inserts history into experience. It establishes the significance of an experience or the sequence of events for the person or persons in question. In thick descriptions, the feelings, voices, actions and meanings of interacting individuals are heard."

These processes of social learning, learning through sharing, skill building and capacity development, enable people to engage with "the global" on their own and better terms. It allows them to disseminate and defend their own strategies, to build partnerships and alliances across differing interests and partnership between the organisations of civil society and the public sector. It involves ethical concepts and ethical practice, the creation of social capital and the engaged facilitation of change.

How then can such a process-oriented approach be evaluated? We have recently attempted to do this and I will briefly outline the methodology developed. The evaluation team believed it important that the evaluation be conducted in a manner consistent with the dynamic and developing nature of the program. One of the critical indicators for evaluating the approach was the extent to which social learning has taken place, as indicated by the emergence of new understandings and approaches as critical indicators of social change. The focus of the evaluation was to be on the relevance and sustainability of the approach and this suggested that the key evaluation questions should centre not so much around "What did this program do?", or even "Why was this approach used?", as around:

- how were the experiences of all concerned in these interactive processes transformed?
- how were these transformative experiences passed on to others? and
- how was the response to the epidemic strengthened and made more relevant and sustainable by these processes of interaction?

Through such questions, it was hoped that a better understanding of capacity building could be reached. The classical focus of capacity building is on initiatives such as training, study tours, workshops, institutional development. But in the context of this approach to the epidemic, capacity building is a complementary concept more closely tied to social capital formation or social capacity building through processes of human interaction. Its focus is in some sense on the non-measurable, on the norms, principles and values by which individuals and communities live their lives and which provide the accountability framework for institutional change and governance.