

The evaluation methodology chosen, was itself interactive and iterative. The interactive process involved working with the partners of the program and others who use similar approaches in their own work to develop a deeper understanding of how these work. The starting point was the program, but the evaluation enabled people to explore program issues with reference to their own lived experiences. This is consistent with the principal that “the perspectives of and experiences of those persons who are served by applied programs must be grasped, interpreted, and understood if solid, effective, applied programs are to be put into place” (Denzin 1989). The evaluation process was iterative in that it started with a reflection about the nature of the program, went back to the field to explore how this understanding relates to action in the field, and then returned to discuss in more depth with the program and so on.

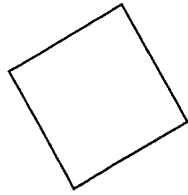
The process was in these ways based on a qualitative research method of *interpretive interactionism* (Denzin, 1989). This method emphasises the need to interpret real life phenomena in order to reduce complex reality to simple understandable and debatable notions. It suggests doing this in an interactive way because deeper understandings about the meanings and significance of experiences and relationships arise when people reflect and engage in dialogue with each other.

The outcome of the evaluation was a deepened understanding of how, in the context of the HIV epidemic in particular but of health promotion and development practice in general, we might better answer the six questions with which I began. The lessons learned from this evaluation also confirm the answers to these questions to be found in the analysis of the practices of the women’s liberation movement in Australia in the sixties and seventies.

These are insights into how we can create processes of change which are essentially endogenous, arising from within collectivities, yet able to be supported and catalysed from without. It provides insights into how such processes can lead to a shared consciousness which grounds social movements in the daily realities of deprivation and human creativity and creates consensus and mutual respect within and among the groups and organisations which make up civil society and nations. In understanding the practice of health promotion in these ways, communities and nations may come to value peoples’ experiences and their ways of thinking and acting. This validation will in itself contribute to increased well-being and social agency, to the incorporation of the personal into the public, and the creation of partnerships across differences, partnerships based on empowerment and participation.

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CHAPTER 2:

Power Relations in Health Promotion

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INTRODUCTION

This book is about how we build effective partnerships for health promotion. It is also about beginning to determine what are the important “benchmarks” or “milestones” in our role in creating these partnerships. Our aim in building these partnerships is to improve people’s health, not only people as isolated individuals or small family units, but also people as a larger public, whether we call that public a community, a population, a nation, a society or a global village.

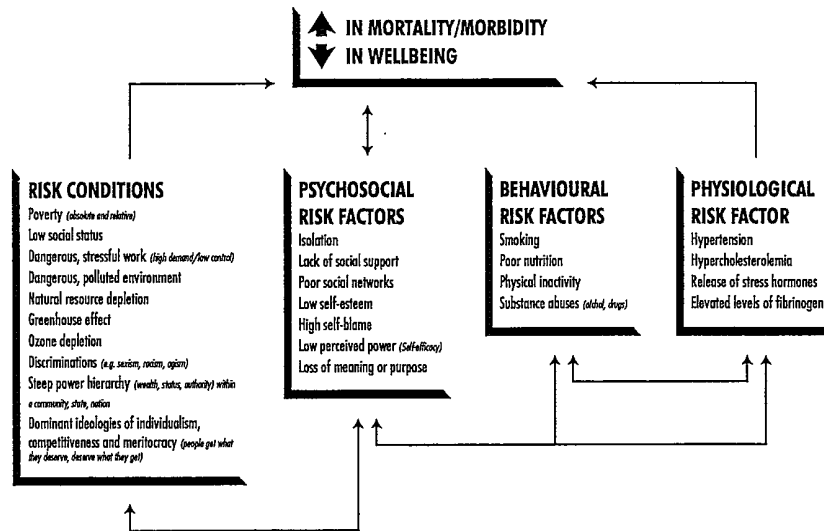
The path towards this end begins by considering two elements that constitute any effective partnership—power, and participation. Power relations invariably structure any partnership, whether between people at an interpersonal level (and that is the first level at which power will be explored); among people in a group or organisation (and that is where the issue of participation enters—what is it that motivates and sustains us in working collectively with others?); or between groups, organisation and institutions, the more formal business of formalising our participation by creating partnerships.

THE RELATIONSHIP BETWEEN POWER AND HEALTH: A SOCIOENVIRONMENTAL MODEL OF HEALTH

Power is an important issue in health promotion. Certainly, recent definitions of health promotion sound very much like those advanced for the concept of empowerment. The Ottawa Charter for Health Promotion defines health promotion as “the process of enabling people to increase control over, and improve, their health” (World Health Organisation 1986). This definition sounds remarkably similar to how Julian Rappaport, an American community psychologist influential in conceptualising empowerment, defines that term as “the process by which people, organisations and communities gain mastery over their lives” (Rappaport 1981, p.3). There is also a considerable body of epidemiological evidence that relates powerlessness to poor health (e.g. City of Toronto 1991, Evans, Barer and Marmor 1994). One simple model of how these “social determinants” interact with more traditional behavioural risk factors (such as smoking, poor nutrition or lack of fitness) was developed by the City of Toronto Department of Public Health, to illustrate what it calls a “socioenvironmental approach to health.” (Figure 1) Some of the evidence and argument behind this model follows.



Figure 1: Disease Determinants



HEALTH OR DISEASE?

The first major issue faced by any health promotion practice pertains to the conceptualisation of health. While public health has long held to the “positive” first half of the World Health Organisation’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 WHO definition (“the absence of disease or infirmity”). Peter 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, the exclusion of people’s lived experiences that Elizabeth Reid argues in the introduction must form the base of transformative health promotion practice. Indeed, and perhaps ironically, people’s experiences of health are more about their experiences of capacity and connectedness than about their experiences of disease or disability. The few health surveys that have asked open ended questions about peoples’ experience of health validate this claim (e.g. Blaxter 1990).

Over a decade of workshops, I have often given participants an initiating task of constructing phrases describing a recent time they felt “healthy” (Table 1). 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 and intersubjective meanings.

Table 1: The Experience of Health

Energised	Meaning in life
Being loved, loving	Able to do things I enjoy
Being in control	Peak physical shape
Fit, fitting in, doing	Happiness
Stress-free	Creativity
Outdoors, nature	Spiritual contentment
Friends, family	Wholeness
Giving/receiving, sharing	Playfulness
Belonging	

These relational experiences are not easily rendered into simple, quantifiable measurements. Yet our health care systems often persist in defining health in terms of disease or behaviours, the reality of “things” rather than the reality of “experiences.” John 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.

Our experiences of health or illness are discontinuous with our experiences of disease. Health and disease interpenetrate; we can induce this from research showing that changes in how well we “feel” affect the progress of disease. (That is, the more positively or optimistically we regard our capacity to cope with or vanquish disease, the greater the chance that we will.) But health and disease do not collapse into each other. Many persons with disease, disability or unhealthy lifestyles often 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, Toronto Community Health Survey 1988). 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). Of course, disease may eventually become so physically taxing that it inhibits our ability to experience health.

The subjective nature of health does not imply that the term loses all precision in meaning (Labonte 1996a). 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. Cross cultural studies indicate that people's experiences of health can usefully be organised under the following categories:

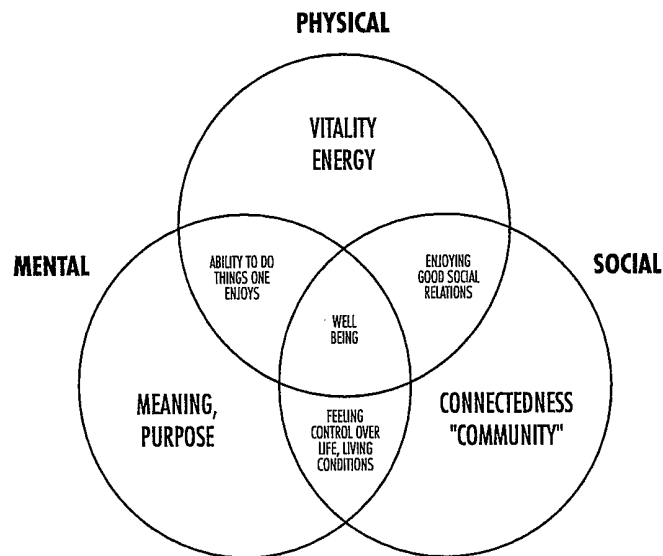
1. feeling vital, full of energy
2. having good social relationships
3. experiencing a sense of control over one's life and one's living conditions
4. being able to do things one enjoys
5. having a sense of purpose in life
6. experiencing a connectedness to "community"

(Antonovsky 1980, Body 1985, Blaxter 1990, Litva and Eyles 1994, Pender 1991, Registered Nurses Association of British Columbia 1990).

Figure 2 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.

Figure 2: Fields of Well-Being



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 if we were interested in “positive” health as an outcome, rather than the absence of disease.

In the socioenvironmental model of health (Figure 1), the outcome is described as both “wellbeing” and as “mortality/morbidity.” Most of the research supporting this model uses mortality and morbidity as its endpoints, and it is probably more accurate to describe this as a socioenvironmental model of disease. At the same time, survey research finds that people who experience the risk conditions and risk factors described in this model are also much less likely to report themselves as feeling healthy, or being happy, precisely because they lack the sense of control or capacity and the respectful social relationships that constitute people’s experiences of wellbeing.

RISK CONDITIONS

The term, risk conditions, describes living and working situations that are largely structured by economic and political practices, and by ideologies (dominant belief systems, e.g. that competition brings out the “best” in people). There is a huge literature that documents the effects of risk conditions such as poverty and other measures of social inequality on health, both for individuals and for whole populations (e.g. Blane, Brunner and Wilkinson 1996, D’Arcy 1989, Gustavesen 1988, Evans and Stoddart 1990, Harding 1987, Marmot and McDowall 1986, Marmot and Theorell 1988, Marmor, Barer and Evans 1994, McIntyre 1986, Smith, Bartley and Blane 1990, Townsend 1986 and 1990, Wilkins and Adams 1983, World Health Organisation 1984, Wilkinson 1986, 1990, 1996). This includes research on the relationship between absolute poverty (where people lack sufficient food, shelter and clothing to maintain good physical functioning) and relative poverty (where huge gaps in wealth distribution are experienced as unfair, a point that will be returned to shortly). Poverty is also associated with lower educational attainment and lower occupational and social status. While education level tends to predict one’s income, much of its relationship to poor health is better explained by a more general experience of “deprivation” (i.e. the overall pattern of living in risk conditions) than by school achievement alone (Blane, White and Morris 1996). Occupational status determines health partly by exposure to workplace hazards, and primarily by one’s position in a social hierarchy of power. That is, poor people are more likely to work in dangerous, stressful jobs (high demand, low control). They are also more likely to live in polluted neighbourhoods.

Another aspect of risk conditions that influences the health of all life on the planet are the effects of human economic and other activities.



These effects derive from the unsustainable use of human resources (depletion of food sources, trees and fresh water), damage to ecological systems that threaten biodiversity (biodiversity refers to the notion that ecologies need an abundance of genetically diverse life-forms for balance and survival), creation and release of toxic pollutants, the “greenhouse effect” (whereby industrial emissions of certain gases raise the overall planetary temperature) and depletion of the protective ozone layer through release of chloroflourocarbons used in refrigeration, and other ozone-depleting gases (Labonte 1993a).

PSYCHOSOCIAL RISK FACTORS

The term, psychosocial risk factors, describes individual cognitive or emotional states, which are often reactions to risk conditions. People living in risk conditions, for example, are more likely to experience less social support and report fewer social networks (Auslander 1988, Berkman 1986). Poor social support is associated with a wide range of health problems and may be a more powerful predictor of how long or well people live than whether they smoke (see, for example, Cohen and Syme 1985). They are also more likely to have low self-esteem¹, be unhappy and experience self-blame and low perceived power (Harding 1987, Lerner 1986). These psychosocial experiences, in turn, increase physiological functioning associated with increased heart and other diseases, i.e. hypertension, hypercholesterolemia, release of stress hormones and elevated levels of fibrinogen, a risk factor for heart disease (Brunner 1996, Berkman 1986, Brindley 1981, House, Landis and Umberson 1988). The presence of these physiological risk factors, including diagnosed disease or subjective illness, may also weaken a person’s ability to maintain social networks and support, which is why the arrow between psychosocial and physiological risk factors is “two-tailed.”²

BEHAVIOURAL RISK FACTORS

The term, behavioural risk factors, describes those individual lifestyles that are the principle foci of much government-initiated health promotion work. People experiencing psychosocial risk factors and socioenvironmental risk conditions are more likely to engage in health-damaging behaviours which reflects, in part, a “stress-buffering, stress coping” strategy, in the relative absence of social support or social networks (Hibbard 1988), or simply a gesture of control within their lives. Health behaviours have complex meanings in peoples’ lives. Qualitative researchers in England found that, for many poorer women, smoking represented their daily moments of control (Graham 1987). When they lit up their “fag,” it was a signal to demanding spouses or children that this was their time. It was a symbolic gesture of power and control. This creates a health paradox. On the one hand, smoking is physically unhealthy for these women; on the other hand, smoking is psychologically (and hence also physically) healthy, because of the sense of control and power it creates. A few years ago, I attempted a conversation on this research with an eminent epidemiologist, who was steeped in the rationality of the behavioural or lifestyle approach to health promotion. He simply responded that these women were wrong.

The idea that it represented control was irrational and stupid. Smoking killed them, period and full-stop. Their perceptions of power? Relativist nonsense. Yet there is abundant anecdotal evidence that, when health professionals work first on these women's "generative issues" (those daily concerns that "generate" their interest), and these women experience more control elsewhere in their lives, lifestyle issues slowly become more important to them (NYCHPRU 1993).

Finally, because people caught in this "web" of risk conditions and risk factors experience less social support and greater isolation, they are often less likely to be active in community groups or processes concerned with improving risk conditions in the first place (Auslander 1988, Minkler 1985). Again, this is why the arrow between risk conditions and psychosocial risk factors is "two-tailed." This "feedback loop" reinforces isolation and self-blame, reinforcing the experience of disease/dis-ease.

EXPLAINING THE MODEL IN TERMS OF POWER RELATIONS

How might we understand better how power relations determine health? To begin answering this question, we need to examine this phenomenon at two levels—the population level, and the individual level.

At the population level, part of the higher rates of death and disease among lower socioeconomic status groups is attributable to a greater prevalence of known individual (physiological and behavioural) risk factors such as smoking, diet, exercise, elevated blood cholesterol and high blood pressure (Millar and Wigle 1986, McIntyre 1986). But while deaths due to specific diseases and their individual risk factors change over time, that less powerful groups suffer more disease and live shorter lives has remained constant. Several decades ago, the poor died more frequently than the rich from infectious disease. Today, they die more frequently than the rich from heart disease, or from some cancers. Similarly, poorer groups in different countries may die from different causes (Smith, Bartley and Blane, 1990) but they die at similarly younger ages when compared against wealthier groups. Canadian data find that if the poorest 20% of the population had the same health status as the wealthiest 40% of the population, they would enjoy 13 more years of disability-free life. If all disease and death from heart disease and cancer were eliminated for the poorest 20%, they would experience only 2 to 5 more years of disability-free life (Federal, Provincial and Territorial Advisory Committee on Population Health 1994). The implication is that even if we can cure or prevent all leading causes of premature death (including improving all those health behaviours that contribute to these diseases), but fail to flatten our social hierarchies of wealth and power, a new set of diseases will arise to kill or disable the poor years earlier than the rich.

Over time, and across nations, the poor appear to be more vulnerable to most diseases, regardless of their specific risk factors (Evans and Stoddard, 1990, Evans, Barer and Marmor 1994). The larger the power gap between top and bottom, the bigger the health gap. A study of male British civil servants, for example, found that a lower position on a steeply graded occupational hierarchy was associated with increased morbidity and mortality risks,



independent of income, lifestyles and exposure to occupational or other environmental hazards (Marmot 1994, 1996). Similarly, amongst OECD nations, those countries having the greatest after-tax income equality also have the lowest infant mortality rates and longest life expectancies, independent of the absolute level of income (wealth) within the country (Wilkinson 1996). Japan, the wealthiest 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 1990, Sullivan 1991). There is also 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)3.

An increasing number of research studies in the UK, the US and other countries confirm the finding that there is something toxic about the steepness of the slope of hierarchic inequalities (e.g. Kaplan et al 1996, Kennedy et al 1996, Smith 1996). As Canadian health economist, Robert Evans, expresses ironically, "the benefits of a hierarchy always look better from the top." Nor can we explain why steep power hierarchies cause ill health by recourse to absolute poverty (which compromises physiological functioning), pre-existing illness, access to health care or even lifestyles. But why do people at a bottom of a hierarchy seem to suffer more death and disease, and live unhappier, unhealthier lives? Here we focus our attention more at research on individuals than on populations. While much of these research findings are speculative, they point in the direction that the explanation for health inequalities lie in how people psychologically experience social inequalities (Wilkinson 1992). Richard Wilkinson, a British researcher whose original work and synthesis of findings in other fields has been instrumental in advancing our understanding of how hierarchies determine ill health, cites studies of hierarchical baboon troops in defense of his findings among human populations (Wilkinson 1996). He argues that lower status baboons, like lower status humans, have less predictability in their lives, are never certain when they will be attacked (criticised? "down-sized"?) by higher status baboons and consequently live in a state of continuous stress.

Applied to humans, we might argue that people living in risk conditions feel distressed by the unfairness of their situation. They internalise the unfair risk conditions they experience as aspects of their own "badness" or "failure," adding to their distress. This situation is more likely when the dominant social discourse or ideology on success is based on individualism and meritocracy, where people are presumed to succeed or fail purely on the basis of their own initiative or ability (Lerner 1986).

This internalisation leads to what philosophers describe as false consciousness, “failing to utilise the power that one has and failing to acquire powers that one can acquire,” (Morris 1987 p.94), what psychologists call learned helplessness (Seligman and Maier 1967, Seligman 1975) and what political scientists label surplus powerlessness (Lerner 1986).

Learned helplessness is a psychological construct that emerged from Martin Seligman’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 them anyway and did not seek escape. Even if they accidentally avoided the shocks, they did not internalise this learning and continued to endure subsequent shocks. They had resigned themselves to their fate; they had “learned helplessness.” The dogs, however, did “re-learn” how to escape after repeated “teachings” by the researchers, in which the dogs were pushed, pulled or prodded away from the area being shocked. Martin Seligman has now coined another term, “learned optimism,” to encompass the dynamic of learning how to develop positive self-images (Seligman 1990).

Michael Lerner (1986), a political scientist and psychotherapist, argues that a similar phenomenon occurs with 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 internalise 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 internalising process is isolation, removing oneself from active group participation because of low self-esteem and self-blame. Survey research affirms this process; poorer people internalise self-blame for their poverty, isolate themselves and set in motion a vicious circle in which peer support declines, self-blame increases and isolation worsens. 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. Compared to control groups, persons in the experimental occupational stress groups demonstrated statistically significant improvements in such areas as social support, health behaviours, absenteeism and perceived power (the research design was randomised, quasi-experimental). 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 organised, 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.