

Socioenvironmentally defined health problems represent the direction for practice announced by such documents as the Ottawa Charter for Health Promotion (WHO 1986), and are often how issues are defined by social action groups or social movement organisations. What health naming does our work proceed from? Who gets to name the health problem?

Brazilian educator, Paulo Freire, talks about empowerment as “speaking the world” (Freire and Macedo 1987). Our first claim of power—power being defined as “the capacity to create or resist change” (Kuyek and Labonte 1995)—is naming our experiences, and having that naming heard and respected by others. We know this from our children. A two-year old knows that naming things is power. She says: This is a dog. Her parent says: No, that is a cat. She insists, perhaps with a sly tilt of her head: This is a dog. The naming is not so much about what it is. It is about who has the authority to name.

There are three basic types of power-over, in which the person exercising power attempts to have others behave according to his or her desires—domination, exploitation and hegemony (Lukes 1974, Foucault 1980). Domination, or the direct exercise of force, is rarer in democracies, but exists in institutions such as the police, the army and any legislation that empowers some people to have authority over others. In health promotion, we see this primarily in quarantine, infectious disease reporting and other legislated powers of medical health officers, or in legislative “healthy public policies” such as those governing smoking and alcohol, or environmental protection. These power-overs are not necessarily “bad” or “wrong,” although they must be recognised for the coercion they represent. We must also recognise that sometimes their exercise can imprison people hegemonically (a concept that will be defined shortly), even while we think we are acting with the best empowering intents.

Consider the example of smoking legislation. At a recent public health conference in Canada, a health minister spoke of the empowering contributions public health has made to community well-being. She then spent 45 minutes describing all of the restrictive smoking legislations and education programs consisting of strong imperatives, stiff fines and the vilification of individual smokers. My co-speaker for the opening speech to follow—on the conference topic of power—was a wise community organiser who worked in poor neighbourhoods. A committed non-smoker, but aware of the stresses and strains that partially underpin higher smoking rates among the poor, she muttered to me, “It’s amazing how we continue to criminalise the poor, rather than criminalise poverty.” To express this another way: Many epidemiologists are now posing the question that, since smoking rates are higher among lower social class people, we should ask ourselves “What is it about social class that causes smoking?” (Evans and Stoddart 1990). That question is fine as far as it goes, but the more important health promotion question is “What is it about society and economy that causes social class?”

Economic exploitation, the second type of power-over, is one cause of social class, and speaks to how the neutral language of the market and the economy work to obscure that, as economist Herman Daly (1989) expresses, the market is blind to distributive justice. Some people gain only to the extent that others lose. Where this touches health promotion practice directly is in the costs of our salaries, our institutions and our programs.

These costs represent a transfer of wealth from poorer communities to wealthier professionals. John McKnight (1987) talks of a study in a poor New York neighbourhood which found that 2/3rds of all public spending went to professional service providers and only 1/3 went in the form of direct income transfers to poor people. He argues that if all public spending had gone directly to poor persons in the neighbourhood, their lives may have been far healthier even with the relative lack of professional services. I don't entirely agree with this analysis and, at the least, no one knows the proper balance between public service provision and individual or community group choice. But it is important to know that every new program or service dollar gained by institutions represents a dollar that is not under the more direct control of less powerful individuals and groups.

It is the third type of power-over, hegemony, that may be the most insidious. It speaks to how our professional powers are sometimes used to control how others come to see themselves—as powerful, or as powerless. Consider two prenatal assessments (Tables 3 and 4). The first (Table 3) represents a typical assessment format that purports to be objective and professional, but which presents an overwhelming burden of difficulties, many of which are actually power-over judgements. “No apparent substance abuse” implies that Marian could still be a substance abuser; she's simply clever enough to hide it. Imagine the behaviours of the health worker who “constructs” Marian in this way, and how these behaviours define Marian by her deficits and problems only; and how Marian, when confronted by such institutions and practices time in and time out, begins to internalise these as being true about herself, creating the learned helplessness or surplus powerlessness discussed in the previous Chapter. For in this hegemonic power-over, Marian, as a person, is completely absent.

There is no evidence of her own capacity or power; no reflexivity indicating whether the way the professional assesses Marian resembles the way Marian sees herself. Instead, all we see are physical and behavioural problems, partly because such problems are what many professionals believe give them their credibility and power. If there were no problems, there would be no need for professional problem-solvers.

Table 3: Judgemental Assessment

- low income, single mother
- inadequate protein, calcium and overall caloric intake
- one-bedroom basement apartment
- first child low birthweight
- insufficient weight gain
- fears labour and delivery
- does not speak or read English well
- no apparent substance abuse

Table 4: Empowering Assessment

- poor appetite due to stress and isolation; child's father political prisoner in Guatemala
- enjoys preparing traditional vegetable soups, bean dishes and corn bread
- would like more milk and meat but finds these too expensive
- healthy 3 year old daughter born low birthweight, no complications
- worried about income and childcare when child comes; refugee status claim still pending
- has cousins locally who can help financially, but not enough
- makes quilts and paints as hobbies; would like to sell her work
- Spanish literacy, school-teacher in Guatemala; concerned poor English skills will be interpreted as stupidity
- small, tidy apartment
- wants fridge; afraid to ask landlord as she can't afford to be evicted

In the second assessment (Table 4), a completely different way of viewing Marian emerges. Here we see her abilities. Here we see many more opportunities for actual change, and for our role in helping that change, e.g. obtain fridge, mediate with landlord, assist in marketing quilts, mediate with national consulate office in Guatemala over release of husband, meet with delivery room professionals in hospital over language concerns. If we fail to look for peoples' gifts—in ourselves, our colleagues, those with whom we work—we simply reinforce or extend the idea that people are powerless to make a difference.

As professionals, our relationships with others always have different elements of all three types of power-over. Our education or training, the higher incomes that we can earn, the types of jobs we occupy, often give us a higher social status. The positions we occupy in institutions often give us some decision-making authority or influence over resources, such as grants or social service benefits, or access to goods and services such as photocopiers, telephones, meeting spaces and so on. Other times our control over access to these resources is more closely linked to our social status.

We have the professional “authority” to give or withhold legitimacy to the named concerns expressed by individuals or groups with whom we work, and so effect their abilities to mobilise public resources. Our social status and authority, in turn, also gives us considerable power to influence or persuade decision-makers further up the hierarchy of power-over systems. We can “set” political agendas around health, and it is in how we define these agendas that we either hegemonise the relatively powerless, or transform that power-over by sharing what powers we possess. (See Table 5).



Table 5: Some Professional Powers

Among the forms of power possessed by health promoters and other health professionals are:

- Privilege, the fact that health promoters have greater access to, and control over, all of the other forms of power in this list.

- Information, especially technical expertise on health matters and information on how the bureaucratic and political systems in government work.

- Position, meaning that health promoters are closer to the corridors of political power and have some ability to influence the public policy agenda. This proximity to politicians and to the political process, is also where the health promoter's privilege and other forms of power in this list derive.

- Social status, associated with the income, occupation and education of health promotion workers.

- Knowledge, including an expertise "legitimacy," that is, the opinions of health promotion professionals are legitimate because they are considered to be "experts."

- A paid job, which often leads to less personal (emotional and ego) involvement with the issues of the community groups. By being paid, the health promoter has the power to walk away from the issue, unlike other group members, and often has more choice over how much time to spend on the issue or with the group.

- In some cases, power or influence over actual funding.

Source: Toronto Department of Public Health 1993

THE LIMITATIONS OF THE EDUCATION/AWARENESS PARADIGM

One of the difficulties faced by many health promoters is letting go of their "education and awareness" paradigm of practice: When in doubt, create a pamphlet. When in greater doubt, create a poster or a video program. Put the above on a mobile display, wheel it into a shopping mall or other public place, and call it community development. Advice-giving is how we often define our own professional usefulness, the way we make our contribution to a larger common good. We know that many people, faced with health and other social crises, value the empathic advice of someone with a bit more knowledge on how services and resources work, or with a broader repertoire of well-being strategies based on professional training and practice. But this advice is often doled out without much attention to listening—the average person with a physical complaint takes on average two minutes to describe it, and the average health practitioner interrupts with a diagnosis in an average 30 seconds—or with little reflection that systems of expert knowledge are limited. A parallel problem persists in the promotion of healthier lifestyles. A few years ago I did some work with Heart Health Coalitions to move them beyond their paralysis with pamphlets, posters and health fairs, and towards the

institutionalisation of good food, exercise breaks and smoking restrictions by working with decision-makers to change workplace or public policies. The best shot at an institutional policy for one of these coalitions, one for which they were prepared to put their careers on the line, was “to increase funding for awareness and education programs on Heart Health.” Harvey Skinner of the University of Toronto’s Division of Community Health recently reviewed a number of studies documenting the effects of advice-giving on health behaviour change (1996). He found that health practitioner’s counselling on lifestyles do seem to make a difference, especially for smoking and alcohol abuse, but when the people who have been so counselled are asked what they remember, it is rarely the content or the advice. Instead, it is the respectful, affirming and motivating qualities of the practitioner—the very qualities of an empowering relationship identified in Table 1.

The limitations of the education and awareness paradigm, of course, move beyond the interpersonal to the programmatic, particularly as it applies to marketing healthier lifestyles. Even though such campaigns may have some impact, they require constant, expensive “doses”—public resources that might better be used to fund community workers from more marginalised or oppressed groups, helping these groups to mobilise more internal and external resources and political legitimacy that, in turn, can transform their interpersonal relations from self-blame to self-help. More importantly, such education and awareness campaigns usually represent how health professionals and institutions “name the problem,” which may not bear relation to the immediate or more deeply structured experiences of people. (Recall the story in the previous Chapter of making the heart health boundaries more permeable.) This dissonance has importance when we consider participation, since a common complaint of many lifestyle-oriented health promotion partnerships is their lack of grassroots community members or groups, especially those living in disadvantaged risk conditions. We often refer to these people as the “hard to reach,” implying that they are the ones who are the problem, when perhaps it is health workers in these instances who are hard to reach because they offer little of immediate relevance or usefulness.² As one volunteer in a lifestyle-oriented health project commented, “[Thinking about why community participation in the program declined] goes back to my question, “whose idea was this?” “What do people volunteer for?” When I look at what people volunteer for, it’s an issue close to our heart” (Goodman, Steckler, Hoover et al 1993, p.215).

If we fail to start with what is close to people’s hearts by imposing our notions of health concerns over theirs, we risk several disabling effects:

- We may be irrelevant to the lives and conditions of many persons, especially less powerful persons whose health (and risk of disease) is partly a function of their relative powerlessness.
- We may further their experience of powerlessness by failing to listen to and act upon concerns in their lives as they experience and name them, communicating to them that they are wrong and that we, the professionals, are right.



- We may further complicate their lives by continuing to insert into them more and more “urgent” problems that they must address and “buy into.” Several writers commenting on the relatively low community participation rates in many lifestyle health coalitions acknowledge that chronic disease may not be an important issue for many lower-income communities...yet. That is, they believe that what is needed first are massive public awareness campaigns. But who are we, as researchers or as practitioners, to claim that poverty or racism are less important health problems than cardiovascular disease?
- Relatively powerless communities are often reliant upon external resources to organise themselves around their local or more broadly defined concerns. Channeling community development resources into narrowly-defined health behaviours, with specified “variables” that should record objective change as an outcome of the community-based activities, also risks channeling the political activism of local groups away from structural challenges and into individual-level changes.

“Starting where people are” requires finding what Paulo Freire (1968) described as communities’ “generative themes”—those issues which spark animated discussion amongst people because they are “close to the heart.” This does not mean uncritically accepting how people come to name their experiences. Instead, it requires a respectful and mutual probing of concerns through the use of open questions that invite reflection, such as “what?” “why?” “so what?” “now what?” (Labonte and Feather 1996). In many poorer neighbourhoods, drugs are often the topic that “generates” heated discussion. But there are many ways to understand the drug problem, as a medical, policing, behavioural or social issue, to name only a few. Facilitating a reflective and critical analysis of the drug “problem” may very well reveal underlying concerns around poverty, unemployment, housing, racism, safety and so on, each of which may lead to different community organising and action strategies which require different relations with health and human service institutions.

TRANSFORMING POWER-OVER TO POWER-WITH

Even when our social situation accords us power-over other people, the intention with which we exercise that power-over can lead to its transformation into power-with. Thomas Wartenberg (1990), a philosopher, cites the relationships between teacher and student, and between parent and child, as exemplars of the transformative use of power. A “good” master and a “good” parent seek “a transformative use of power—that is, a use of power that seeks to transform the very relationship within which it is exercised” (p.137). The only time the use of power-over transforms to power-with is when it effectively seeks its own ending.

It is here, though, that we might consider two forms of power different from that of power-over: power-from-within, and power-with. Power-from-within is the personal power I have, my energy, self-knowledge, self-discipline, character. It is shaped by my world, and by my beliefs, but it is still about me, and what I can claim as my own. Power-with is the collective side of power-from-within. It is the energy and optimism we create when we act together. It is the greater strength we develop to oppose the practices of power-over when we pool our different abilities and learn from one another. Power-from-within and power-with do not

have a clear material base. They are more connected with feelings and energy flows between people. They are about how we treat one another in thought, words and action—with respect rather than mere tolerance, with a desire for other's security and growth rather than simply our own self-interest.

A few years ago I worked in Aotearoa/New Zealand, and spent time with Maori. Maori suffer in the same ways that indigenous colonised people suffer. Many of them are poor, unemployed, victimised and self-victimising with alcoholism and abuse. Sympathetic Pakeha (as Maori refer to others) go to great lengths to decry the powerlessness and impoverishment that create their poor health. They want to focus attention on what we now call the “determinants of health”—poverty, pollution, discrimination—all of which are effects of a social system whose dominant paradigm is power-over. Pakeha health workers do not want to blame poor Maori health on their high smoking rates, poor nutrition habits, bad parenting skills or lack of family planning. But to many Maori, this explanation is little better than the lifestyle victim-blaming it replaces.

While they lack the legislative authority to re-organise their communities as autonomous political systems, many Maori are doing so anyway. In one instance, they used government funds for a computer-training program for unemployed youth to develop their own census of every Maori woman, man and child. Their intention is to keep tabs on the individuals in their communities. When a person begins to run into difficulties, counsellors and healers from their extended families can act to re-integrate them in ways that are more in keeping with Maori culture. I asked the Maori leaders who had developed this program, “How can you do this? You don't have the authority or power to do this.” They replied, “We act as if we have the authority and the power. And in acting this way, we develop the very authority and power you say we do not possess.” There is even a name for this stance: *tino rangitiratanga*, or “acting from the position of Maori chieftancy,” more commonly defined as Maori self-determination.

This is power-from-within. It is grounded in a faith that one is acting morally, in a way that invites harmony in relationships with one another, and with nature. “Faith,” as the late Canadian theologian and literary critic, Northrop Frye, commented, “starts with a vision of reality that is something other than history or logic...and on the basis of that vision begins to remake the world.”

We are often blind to this form of power, in ourselves and in others. We are blind partly because the institutions in which we work are defined exclusively by “rational” knowledge systems, by “objective” conditions that can be independently measured, manipulated for pre-determined ends, or “controlled for,” and just think of the power-over in that phrase! We wind up looking for problems rather than capacities, as the example with prenatal assessments illustrated.

The example of the assessments illustrates one of the ways in which health promoters have used their power-over transformatively. An assessment that built from capacities rather than advise only on weaknesses did not preclude the nutritionists from also offering advice, but the context was now shifted to genuinely “offering” rather than presumptively “giving.”

Numerous other examples of the transformative use of power-over exist in health promotion³:

- In support group work: A mental health worker was requested by a group of poor women to present to housing authorities their complaints of sexist behaviours and violence in their apartments. They were afraid that, because of their own low social status (many of the women had formerly lived on the street), their voices would not be heard. The worker took their stories and concerns and became their voice during a meeting with authorities, lending the women's complaints the legitimacy of "professional" expertise. But she only agreed to this task on the basis that the women would learn from the experience to become their own advocates. Failing to motivate these women to act on their own when they were ready to would have been no more transformative than failing to advocate for them in the first instance.
- In community organising work: Toronto has experienced a large influx of immigrants and refugees from East Africa. A few leaders from these communities approached the Toronto health department's multicultural health workers, seeking their assistance in efforts to mobilise new resources for their youth. The workers believed that each of the individual national "communities" was too small to be effective. They thought that, in the Toronto reality, a new identity had to be created, one that "would leave behind the politics of where they came from." They interviewed different national groups on their concerns for their youth. They organised a forum for all East African refugee and immigrant groups, involving many of the youth themselves. They used their expertise, political knowledge and power-over financial resources to forge a new, useful, healthy and empowered "East African" community identity. At the same time, these workers attempted to form a single funding organisation of all the different ethnoracial health groups and committees. The idea was to create a stronger lobby for resources. But the effort failed. The different groups were still more concerned with their autonomous control over resources. They did not have, or wish to have, a strong identity as a "multicultural health community." The workers backed off, not forcing the issue.
- In community organising: A community developer, supporting the work of tenants organising around food issues in a public housing neighbourhood, intervened when the residents were told by housing authorities that it was against policy to provide them with garden space in the surrounding grounds. Using the nominal legitimacy that the program was an initiative of a large and powerful health department, the worker arranged meetings between the tenants and senior managers in a number of departments, leading to garden space, top soil, garden plants, space for community dinners and numerous other practical resources. Again, the worker's involvement was contingent on the tenants learning how to access these resources on their own in the future. Like the mental health worker, it was within the community developer's "power" to choose to do so.

- In coalition advocacy: When plans for progressive welfare policy reform were stalled due to their costs, health departments joined with coalitions of social justice, labour, church and anti-poverty groups to pressure senior governments. The external status of health professionals and authority of their research studies were used to support the stories and demonstrations of less powerful and legitimate groups to lobby structural welfare reforms. Had the professionals chosen the “easy way” to policy participation, cobbling together their own briefs and deputations with no effort to work with or support the voices of the less outspoken or marginalised, they would merely have entrenched themselves as the “anti-poverty professionals,” the “social justice experts.”

In each of these situations, there was a dialectic of power given and power taken at the same time. This dialectic is best captured by the wise words of Lilla Watson, an aboriginal leader, who challenged the “helping” professions that “If you come here to help me, you are wasting your time. But if you come here because your liberation (your health) is bound up in mine, let us begin.” This statement encapsulates the essence of practitioners’ ethical stance: Using power-over for the purpose of others becoming more powerful by discovering their own power-from-within.

ZERO-SUM POWER-OVER AND NON ZERO-SUM POWER-WITH

Struggles around power are simultaneously zero-sum (someone loses power in order for others to gain, the “win/lose” dimension of healthy social change) and non zero-sum (working at all times to build empowering relationships).

ZERO-SUM POWER-OVER...WIN/LOSE:

Zero-sum power, a concept frequently used in sociological, political and economic accounts of power, holds that there is only so much of it around. One can only possess x amount of power to the extent that someone else has an equivalent absence of it. This zero-sum form of power constitutes the “win/lose” equation of power. My power-over you, plus your absence of that power, equals zero. For you to gain power, you must seize it from me. Some examples of zero-sum power include:

- control over (possession of) income, wealth, material resources, land, goods

At any point in time people within a country (a society) possess only so much income or wealth. This distribution is zero-sum. For some to have more income (wealth) others must have less.

- control over decision-making (authority)

Decision-making authority is also zero-sum. One only has such authority by virtue of others not having it. This is where power-over decentres somewhat because a person may have authority in one situation, but not in another. He may be a parent at home, and a front-line teacher in the school; she may be an administrator in the system, and a university student in the evening.



- control over ideology reproduction (dominant beliefs, values) via media, school, other forms of socialisation

Or, as they say, freedom of the press belongs to those who own the presses.

- social status (privilege)

Social status is another form of zero-sum power; one can only be high in status if others are low. Once again, social status changes by situation. A person may have relatively low status as a janitor for the school, and have relatively high status as a leader in his church community.

NON ZERO-SUM POWER-WITH...WIN/WIN:

Non zero-sum power-with summarises our ethical stance. Some of the principle elements of this continually expanding form of power (when I possess more of this power, so does everyone else) include:

- **respect**

Respect differs from tolerance. When we are tolerant, we are saying "You are entitled to your views, I am entitled to mine." There is no effort to understand difference. When we are respectful, we endeavour to understand why others think and act differently than ourselves by trying to imagine ourselves in their lives as completely as possible. When we are respectful, we are caring.

- **generosity**

The Sufi spiritual discipline defines generosity as "doing justice without requiring justice." We act for the good of others not because we expect others to act for our good in return; we act for the good of others because it is the only "right" way to be in the world.

- **service to others, from an ethic of caring and justice**

Service to others teaches us humility and affirms our fragile interdependence with one another, and with the planet.

Robert Ornstein and David Sobel in their book *The Healing Brain* claim that these three universal religious principles (respect or caring, generosity or justice, and service to others) are not just good moral principles (Ornstein and Sobel 1987). They are also linked to our own health and well-being, and that of our communities. People who care, who practice justice, who serve others are individually healthier than those who do not. Their actions also create more health for their communities and for the planet. In a profound sense, failure to practice civil behaviour is a serious health hazard, for individuals, communities and societies. It is the "health message" of the new millenium that health promoters must begin to communicate, not simply through their marketing messages, but through their day to day behaviours with clients, communities and colleagues.

These non-zero-sum attributes are not finite; the more I possess of them, the more those with