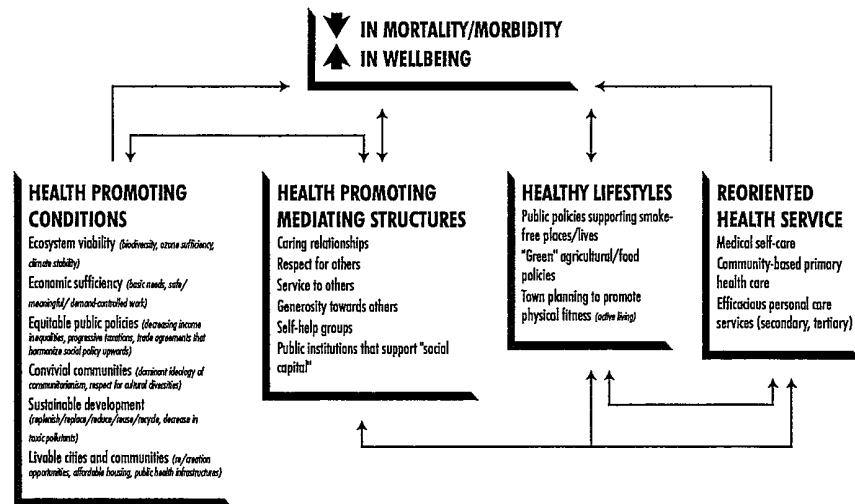


RE-MODELING THE DETERMINANTS OF HEALTH

Figure 1 is primarily a model of disease determinants. However, it can easily be re-modeled to represent the determinants of health, based on the evidence and arguments presented above. This new model (Figure 3) includes some indication of the types of public policies that might lead to creation of healthy conditions, healthy psychosocial relations, healthy behaviours and healthy physiology. It also aligns the six dimensions of health in Figure 2 with the different “boxes” of health determinants.

Figure 3: *Determinants of Health*



IMPLICATIONS FOR HEALTH PROMOTION PARTNERSHIPS

There are several important implications for health promotion practice of a socioenvironmental model of health (Figure 3) or disease (Figure 1) determinants. At the level of national and international public policy, the “empowerment” question for health promotion is only partly one of how much wealth a nation creates. A nation needs sufficient national income (or at least national resources, income being only a resource-exchanging device in most market economies) to prevent physically compromising poverty (Smith 1990). But once that is achieved (which is certainly the case in wealthy countries such as Australia and Canada), the more basic health promotion concern is how equitably that wealth and the decision-making power it provides is shared within the nation. At the level of practice, working to overcome the learned helplessness or apathy, as it is sometimes judged, of less objectively powerful persons becomes important work, and in three senses. It is immediately healthful for the psychosocial wellbeing it creates. It may improve health behaviours over a longer term. It is an essential first step in mobilising community actions in support of those international and national policies that will create more economic and political fairness.

A socioenvironmental model of health also leads to a change in how health promoters explain differences in health status, and where they might choose to focus their resources. In terms of

“targeting” health determinants, for example, the socioenvironmental model rejects the notion of high-risk “target groups,” a term which continues to dominate behavioural or lifestyle approaches to health promotion policy and program work in many countries.

Consider the concept of “target,” the first meaning of which is something to aim or shoot at, and, forgiving the violent image, leaves unaddressed who determines what should be our targets or whether having them makes any difference, since the important act is learning how to draw the bowstring, not how to paint the bull’s-eye. But it is “target’s” second meaning that is more compelling. To be a target is also to be the object of attack or criticism which, given the seven deadly secular health sins of smoking, gluttony, smoking, sloth, smoking, drunkenness, smoking, and today’s new eighth—failure to know the difference between high and low density lipoproteins—is not that far off the mark. This notion of “target group” locates the problem and its solution within the characteristics of individuals and groups. This is the very tendency that Ryan (1976), in his study of attitudes to US blacks, cautioned us was victim-blaming. We communicate a message of deficiency to people living under structured conditions of inequality or unfairness. Our actions are streamed towards small populations and away from political and economic structures of decision-making power.

The socioenvironmental model, instead, emphasises more the notion of risk conditions, and here there is a basic shift from seeking health promotion cause, explanation and change in an individual or group, to seeking it in societal structures of power-over. This significance of this shift is best captured by the following fictionalised account of differing concepts of “risk” for African-Americans.

It’s the early 1960s, and a university researcher in the northern US is eager for more publications to secure tenure. Being the early 1960s, this researcher is both male, and white. Being a university researcher, he is also middle-class. We’ll call him Bill.

Bill decides that it would probably be worthwhile studying heart disease amongst the Negro population, as African-Americans were then called. After all, he’d been keeping heart disease figures on his students and their families for a few years now, so there was a racial comparison group already in place. And researching racial differences had become scientifically fashionable, despite the lack of any theory of race or any clear intention for making the comparative studies.

So Bill gets ready to find a Negro study group. He figures that the best place to find one is in the US south, the “Deep South” as it was then called, and still is today. Being a racially sensitive guy, he realises that his being white wouldn’t really endear him to his research subjects. So he hires a couple of black public health nurses, arms them with surveys, sphygmomanometers, letters to gain them access to local disease data bases, and a curious invention called a reflectometer. This device records the amount of light bouncing into it on a 5 point scale.

If a nurse points it at the face of one of her black research subjects (black being the colour that absorbs most light) the amount of light “reflecting” back on the 1 to 5 scale allows her to record the blackness of each subject. (Perhaps here we see an unstated theory of race: It’s about skin colour on a 5 point scale.)

Bill, being a man before the era of civil rights gave rise to an era of women’s challenge to patriarchy, chose only Negro men for his studies. One moral of this whole eventual story is that we don’t know if it applies to women.

Anyway, the nurses go about their business, hypertension-reading, disease-tracing and reflectometering away, gathering all kinds of numbers that Bill thinks are important. Bill gets these numbers, crunches them all up, compares them to the numbers he already has on the families of his white students, and publishes the astounding results:

NEGROS HAVE 4 TIMES THE RATE OF HEART DISEASE AS WHITES.

Of course, Bill couldn’t explain why Negroes had four times the rate of heart disease as whites. He left that to other researchers. Some, the sociobiologists and geneticists, thought that maybe, just maybe, it was like sickle-cell anemia, something in their genes. Of course, there were few if any Negro sociobiologists or geneticists to say, “Ummmm. Just wait a minute here? In our genes? Like maybe slavery was a biological necessity?”

Others, the public health behaviourists, took a look at southern fried cooking and had different ideas: “Too much fat! Too much salt!” And on it went. But one indisputable event occurred: Negroes became invested by all the suitable health authorities and disease charities as a “high risk group” for heart disease.

Well, the 60s pass on, Bill gets tenure and the US gets the Black Panthers, one of the more effective self-help groups in recent history. (The Panthers grew up from the “grass roots” of the civil rights campaigns in the rural Deep South, and moved into the “concrete roots” of northern city ghettos, offering education, instrumental support, hot breakfasts and lunches and a war against drugs, which they argued were the enslavers of the Black Nation.) Whatever one thinks of the Black Panthers, they made one grand announcement: Black is Beautiful, Negro is Out, and poor, old Bill was caught with his “honkyism” (white biases) exposed.

For Bill had made one simple, almost forgiveable error. In comparing Deep South Negroes with Northern College Families, he had failed to take into account that the former were dirt poor, while the latter were ivy rich (or at least grass-lawned middling).

Other university researchers, in search of their own tenure, re-crunched Bill’s data, controlling for income, and guess what?



**POOR BLACKS AND POOR WHITES BOTH HAVE 4 TIMES THE RATE
OF HEART DISEASE AS RICH WHITES!**

Except for one little blip that might have been overlooked had not Bill had the theoretical foresight to arm his nurses with the reflectometers. For there was one statistically significant, though not terribly large, anomaly. Blacks who scored highest on the reflectometer scale, blacks who were the darkest of the darks, still registered a higher incidence of heart disease.

Did this mean refining the genetic theory?
Or fine-tuning studies of dietary practices? Perhaps.

But it could also mean a simple “qualitative” return to the “quantitative” research, a trip back to the Deep South and a short discussion with the 5 point reflectometer subjects.

“Shit. You want to know why I got so high blood pressure, such a bad heart? Look at me. What do you see? Black. Real black. And then look over there—at that cop, at that store-keeper, at them landlords, and what do you see? White. Real white. And you wonder why I feel stressed?”

And so, the moral of the story is that blacks are not high risk groups for heart disease. Poverty and racism are high risk conditions.

(For a brief discussion of research findings and interpretations of the “race” difference in US male heart disease rates, see Tyroler and James 1978, and Pappas et al 1993.)

In other words, cancer and heart disease are not the leading causes of death, as is often claimed in health promotion. Rather, poverty and discriminations are the leading causes of death, for which cancer and heart disease, and their related health behaviours, are simply two of many “vectors.”

MAKING THE PRACTICE BOUNDARIES PERMEABLE

This story does not mean that health promoters should ignore lifestyle health issues, although it does mean that they should pay more attention to their limitations in creating a healthier public. Nor does the socioenvironmental model of health mean that health promoters or the health sector shoulder solitary responsibility for social injustice. But it does imply that the amount of health resources and program attention that presently go to the “boxes” of medically or physiologically defined risks, or to behaviourally defined lifestyles, needs some redirection. The empowering health promotion task is, first, to locate these diseases and behavioural risks in their psychosocial and socioenvironmental contexts; second, to recognise these contexts as independent health risks in their own right; and third, recognise that what becomes important is acting around all the problems in the “web,” a task so vast and the responsibility of so many groups, institutions and sectors that it demands effective partnerships.

In simpler terms, and as health promoters themselves express, the task is one of “making the practice boundaries permeable.” For example, lifestyle behaviours are only rarely “generative” themes for society’s most marginalised. At the same time, you can imagine the response a health promoter might receive when he comes knocking on doors in a poor neighbourhood announcing:

“Hi! My name is Ron. I’m from the community health centre. Did you know that your lousy housing, your poverty, your unemployment and your general oppression is making you sick? I’m here to work with you to build an empowering community project to take greater control over these socioenvironmental determinants of health.”

Knock on a hundred doors, and odds are a hundred doors will be slammed in your face. We know from countless stories in the community development “wisdom” literature that people either organise in reaction to a threat, or mobilise on short-term, “doable” activities that provide them with immediately useful and pleasant results. As Meredith Minkler, one of the US mother’s of contemporary health promotion, tells us, most people “want to make their lives,” not make history (Minkler 1985). So imagine another practitioner who knocks on the same hundred doors and announces:

“Hi! My name is Meredith. I’m from the community health centre. Summer is around the corner, and some of us in the health department, together with the local churches and neighbourhood association, thought a community picnic in the local park would be nice. We’ll supply the food. We need some help in organising some activities for the kids, and we’re thinking of developing a “fun” run, walk, bike or shuffle around the neighbourhood that would look at the gardens and some of the spots people find interesting. Would you like to join our organising committee? We meet Tuesday nights. We’ll supply transportation, childcare if you’ve got kids, and the local church is providing dinner.”

Ninety doors might get slammed in your face, but ten will not, and a new community organising nucleus emerges.

Notice that there’s no mention of cardiovascular disease, lean cuisine, low density lipoproteins or physical fitness. Also, by participating in heart health activities superficial to more structural and complex experiences as poverty and oppression, residents in this rather devastated neighbourhood could begin to move through their sense of helplessness. As one participant in the real heart health program upon which this fiction is based expressed, “This program is the first time anyone asked me to help them, and let me know that I have succeeded in something.” It was much easier for locality residents to organise and experience some successes around issues of nutrition or fun-runs than around poverty. These successes buoyed them to begin (again) tackling the more deeply rooted problems of their social status and condition.

And so, if you were Meredith, you would probably notice that, six to twelve months later, the organising nucleus you helped to create might begin muttering about issues such as unaffordable housing, the threat of another plant closing in the neighbourhood, cuts to welfare programs looming in the legislature.



In the tightly “boxed” heart health behavioural approach, Meredith would shrug that it is not heart health, not in her mandate. In a permeable heart health program with open lids between the medical, behavioural and socioenvironmental, Meredith would view heart health and the summer picnic as metaphors or entry points into the richly complex lives of the residents, fully prepared to ask of herself when these risk condition concerns begin to surface: What can I and my health agency do to support these persons in these social justice endeavours?

Asking and answering this question is what makes the boundaries in our different practice “boxes” permeable, and what allows our practice to become more broadly transformative. While not universally asked or answered within all institutional corridors, this is a question more senior bureaucrats than we might imagine would like those of us in the front lines of practice to pose more assertively and more often than we do.

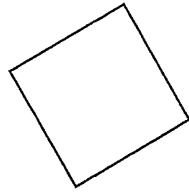
What is important in our health promotion work, then, is less where we start and more where we go, and how well we travel the path. How we travel this path, in turn, is determined by our ethical stance, how it is we approach the people with whom we work. It is here we encounter the essence of a participation philosophy, its core “empowering values,” what Elizabeth Reid called “the ethical guiding principles” that determine how we go about creating our partnerships.

¹ *Self-esteem has become one of the empowering health promotion flavours of the month. Many school boards, social agencies and training programs now focus on developing self-esteem in people, particularly among members of more socially oppressed groups. In almost medical fashion, self-esteem is conceived of as a discrete treatment, sucked into the syringe of packaged programs that are then administered as a panacea. On the one hand, that objective (socially structured) powerlessness often becomes internalized in negative self-image is an important insight into the path of personal and social transformation. On the other hand, much of the present emphasis on self-esteem suffers from two ideological and interrelated blindspots:*

- *It focuses on the self rather than the self-in-relation to others.*
- *It emphasizes the power of positive self-imagining to the relative exclusion of critical analyses of historic power relations.*

Self-esteem, or positive self-regard, is a social phenomenon and not an individual creation. It is constructed through a variety of group memberships and socially formed identities (Abrams and Hogg 1990). It is not grounded in the self, but in the self-in-relation to others and to ideologies, or dominant belief systems. These social relations, in turn, are heavily conditioned and constrained by the histories, resources and opportunity structures that people are born into. Self-esteem, then, is not some simple attitudinal construct that can be manipulated by skilled program architects; nor is it a feeling of superiority over others. It might best be thought of as “social esteem.” For what are we communicating if we advertise self-esteem programs targeted to women, youth, the unemployed, members of ethnoracial minorities, the poor, elderly—anyone, in fact, who isn’t white, middle-class, middle-aged and male? That the problems you face are still about you, your self-esteem, your sense of self, and not about the deeper, structural economic and political conditions that privilege a few and oppress the many. As one community nurse in Canada complained, “I put up notices for self-esteem programs for younger single mothers all over the housing complex, it’s what they said they all wanted, but no one signed up and no one came.” I wonder why. (For more discussion on the issue of self-esteem and health, see Raphael 1993.)

- ² *It is important to emphasize that there is not a singularly causal relationship between risk conditions and psychosocial risk factors. Wealthy, powerful, well educated and employed persons may also experience psychosocial risk factors, just as people living in these risk conditions may not experience them. But people living in risk conditions are more likely to experience psychosocial risk factors.*
- ³ *There are problems with assuming that Japan’s economic growth and “collective esteem” are health promoting models worth replicating globally, as sometimes occurs (e.g. Evans, Barer and Marmor 1994). Japan has accomplished much of its prosperity and life expectancy gains only by imposing an enormous ecological “footprint” on much of the rest of the world. The notion of an ecological footprint is that the lifestyles and prosperity of western societies rest primarily on control over the environmental resources of poorer nations. By one estimate, per capita North American lifestyles require 4.6 hectares of arable land; for childless professional couples, this rises to 13.5 hectares. Globally, only 1.7 hectares per capita is available (UBC 1994, pp.116-7). The difference is what wealthy nations appropriate from beyond their own boundaries. In other words, there are finite limits to wealth generation and an ecological imperative that must override economic ones. The notion of “collective esteem” also raises a spectre of ethnocultural elitism and indicates the impossibility of undesirability of prescribing any singular prescription against the powerlessness/disease relationship. However, the point that power equity (a flattened hierarchy of social status) is associated with improved population health indicators still stands. (For a discussion of these points, see Labonte 1996b).*



CHAPTER 3:

Power and Empowerment: Building Transformative Relations from the Inside Out

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INTRODUCTION

The previous Chapter identified a socioenvironmental model of health determinants and argued why power relations are central to participation and partnership practice. In simpler terms, and as French philosopher Raymond Aron once stated, “When inequalities become too great, the idea of community becomes impossible.” Many of us, particularly those from smaller towns or villages, have experienced this. In our working lives, it is sometimes called “the tall poppy syndrome;” if someone stands out too much in our community landscape, the gap between them and us yawns greater and our ability to interact with them as people, as members of a community, weakens. The same is true in our interpersonal relations with our colleagues, “clients” and community partners.

There is a Sufi parable, backed up by a library of educational theory and knowledge, that no one can teach another what they do not already know, or at least what they cannot discover for themselves through reflections on and analyses of their own experiences. To honour two of Elizabeth Reid’s opening challenges—to create space for these reflections, and to address “how one can give an account of knowledge, and of morality, that retains continuity with daily experience”—the first of our workshop exercises makes ourselves subjects of our dialogue.

EMPOWERING RELATIONS (EXERCISE 1)

All of us have experienced moments in our lives or in our work when we have felt powerless. We have also experienced times when these feelings and conditions of powerlessness were transformed through the actions of others around us.

Think of a time when this transformation occurred.

- What behaviours by others aided this transformation?
- What attitudes towards you did the others have that allowed you to experience this transformation?

Behaviours are what we see; they are the concrete actions of others. Attitudes are what we infer motivates the person to behave in that way. For example, “active listening” or “timely advice giving” are behaviours. “Respect for my concerns” is an attitude that motivates the behaviour.

In paired interviews, share your experience and record key insights to the following questions:

- What behaviours by others aided my transformation?
- What attitudes towards me did others have that allowed me to experience this transformation?



- How did it “empower” me?
- What did I learn from the experience?
- What new actions in my own work can I take from what I have learned?

OUR ETHICAL STANCE

The central behaviours and attitudes of an empowering relationship constitute our “ethical stance.” An ethical stance describes how we act in the social world, the bases upon which we create wellbeing with one another and mobilise our collective resources to challenge structured risk conditions of inequality. Table 1 (below) is a synthesis of these attributes, derived from insights generated from this exercise. These attributes are loosely divided into those that primarily concern process (how we communicate in our empowering relations) and content (what we communicate in our empowering relations).

Table 1 is not a prescriptive list, for how we act to empower others changes with where others are in their own lives. It is often important, especially in creating initial trust in relationships, to be non-judgemental. At other times, being analytical, assertive and solution-seeking may be more appropriate. Moreover, none of us is perfect and, though we espouse these practices, we often fall short; we need forgiveness of one another in our own communicative transgressions. Yet the list is a testament to the canons of moral, or civil, behaviour. They are the mortar with which we cement what Elizabeth Reid, and others (e.g. Putnam 1993), now describe as “social capital”—the wealth generated in our care for, rather than competition with, one another.¹ As some discussed during the workshop, these behaviours are only infrequently encountered in workplaces (governments or non-government organisations) that purport to be health promoting. These organisations are often steeply hierarchical, leading to situations where, as one cynical health promoter once expressed, empowerment work is where the socially powerless meet the organisationally powerless. This is not an insignificant comment, since studies have found that persons with little organisational authority are more likely to derogate or victim-blame their clients (e.g. Finne 1982). In order to share power, one must first experience it.

This conundrum is becoming more serious as the globalisation of economic decision-making, in the absence of strong transnational agreements on public policies and programs, is reducing the national resources available for such social capital building infrastructures as health, education and welfare services (Friedmann 1992). Despite their often disempowering pasts, these are essential bricks our ethical stance helps to cement together to create healthier communities. Health systems are in a constant state of re-organisation. Fewer resources means heightened job insecurity. There is little ideological leadership for transformative health promotion work from the “top”—or so I have heard expressed throughout Australia, Aotearoa/New Zealand, Canada, the United States and the United Kingdom. The result is an organisational chaos, almost an organisational vacuum, in which many practitioners and their managers begin to protect personal turf and distrust different disciplines and colleagues, or cling defensively to old patterns of work in the hope that it will provide some security or stability. There is less of the ethical stance in our work, even as we need more of it.

Table 1: What Empowers in a Relationship

BEHAVIOURS	ATTITUDES
Process	
active listening	non-judgemental
eye contact, open body language	non-threatening
validating, positively reinforcing, trusting, identifying inner strengths	belief in person's capacity/ability
calming	caring, valuing the importance of "being in the moment"
sensitive, slow in advising	respectful
self-talking, open, sharing, negotiating, abandoning expert jargon	empathic, reflective
assertiveness	willing to challenge
affirming, motivating talk	optimistic
forgiving	caring, permitting human mistakes
hearing our voice	willing to learn with others
Content	
materially, emotionally supporting, persisting	committed to person
linking self to others, to resources	creating change through larger mutual support networks
risk-taking, reaching out, accepting power inequalities as part of problem's roots	willing to give up power, wishing to create equity (fairness)
sharing ideas and strategies,	analytical, critical,
providing perspective	having a wider view
focusing on problem/solution	creating positive change in the short term
affirming spiritual connection	acting from spiritual base, beliefs
solution-seeking, modeling	solution-oriented



If there is any immediate lesson to be drawn from identifying the canons of empowering relations, it is this: That we discipline ourselves to practice them as best we can, each day, with each person we meet, be that person a colleague or co-worker, a client or community representative. Transforming our relations of power within our workplaces is no longer simply a necessary means to the end of broader community empowerment and more empowered health promotion partnerships. It is also an end in itself. And optimism, the belief in our personal and collective abilities to create healthier futures, is no longer simply a personality trait or a sunny-sided disposition. It is also an essential strategy in challenging the pathological practices of power-over and those risk conditions discussed in the previous Chapter.

THE DIFFERENT PRACTICES OF POWER-OVER

This brings the discussion to the matter of power, or the heart of empowerment. There are different forms of power, some of which embed the “win/win” empowering relations defined in Table 1, and others of which involve the “win/lose” exercise of challenging some people’s power-over others. A transformative health promotion practice requires attention to both.

The first point where health promoters confront the issue of transforming power relations is in how health problems are named, and who has the authority to name them. The medical, behavioural and socioenvironmental approaches to health (see Table 2) are somewhat ideal-typical but, in postmodern argot, represent different discourses with different organisational biases (Labonte 1993b).

Table 2: Leading Health Problems by Three Approaches

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

Persons working in health care organisations tend to define health problems as matters of disease or disability. Persons working in public and community health agencies often define health problems in lifestyle or behavioural terms.

