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Chapter 1

Power, empowerment and public health practice in context

■ Introduction

Public health is an approach that aims to promote health, prevent disease, treat illnesses, prolong valued life, care for the infirm and to provide health services. Traditionally, such goals of public health have been used to curb the spread of infectious diseases and to protect the well-being of the general population whilst others see a much greater role in regulation and reducing inequalities in health (Baggott, 2000). The range of goals also means that the term ‘public health’ is used to cover a number of specialist areas including environmental health, nursing and health promotion. Not surprisingly, public health remains a contested and contradictory term given the wide range of competing perspectives, priorities and services that it claims to deliver.

The different interests within public health help to shape what it looks like and the directions it takes as a professional practice by competing for limited resources, the control over decisions and the development of national policies. Public health also involves ‘communities’ and incorporates methods that connect collective action to the broader aims of political influence. Power and empowerment are key concepts to a public health practice that seeks to redress inequalities in health and to change the determinants of health through collective and community-based action.

In practice, public health still belongs primarily to people employed in the health sector, in the sense that it provides these workers with some conceptual models, professional legitimacy and resources. These people may be titled ‘public health promoters’ or ‘health practitioners’ while many more who look to the idea of public health occupy jobs such as health visitors, nurses and doctors. In this book, I refer to all these people as the ‘Practitioner(s)’.

As a profession, public health is largely controlled by government departments, private sector agencies or Non-Governmental Organisations (NGOs) who employ Practitioners as ‘professionals’ to engage in programmes designed to improve or maintain the health of individuals, groups and communities. Professional groups within public health are expected to display a specialisation of knowledge, technical competence, social responsibility and services. Their level of professionalism is attained through education, specialised training, the testing of competence by formal examinations, the membership of a professional organisation and the inclusion of a professional code of practice (Turner and Samson, 1995).

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Public health always entails some power relationship between different stakeholders, primarily between Practitioners and their clients. Practitioners are employed to deliver information, resources and services and are often seen as an outside agent to the people who are their clients. The term ‘clients’ covers the range of people who act as the recipients of the information, resources and services being delivered to promote health, for example, pregnant women, school children, the unemployed and concerned groups of individuals such as residents or organisations who have been formed to address a specific issue. I intentionally use the terms ‘Practitioners’ and ‘clients’ because they help to demonstrate the unbalanced power relationship that exists in public health practice.

One role of the Practitioner has traditionally been as an enforcer of public health legislation, for example, the Environmental Health Officer or ‘Sanitary Policeman’. The role has been supported by much of the work of environmental health departments that are concerned with inspection, licensing, complaint investigations and legal proceedings. An enforcement of the wide range of public health, health protection and food safety legislation by Practitioners has been seen to be necessary to maintain a healthy and safe environment in the home, at work and during recreation. The role of the public health enforcer has helped to establish the image of some Practitioners as that of professionals with power-over their clients through the use of legislative controls.

Another role of the Practitioner has been concerned with education, training and specialist services, for example, as that of a nurse providing advice to a group of young mothers or providing treatment to their patients. This role has helped to broaden the image of the Practitioner as a health professional with ‘expert’ power and access to superior technical resources, skills and knowledge.

There is a further role of Practitioners, one that has developed more recently and that is complementary to their roles as enforcers, educators and specialists. It is an important role that has been largely overlooked because many Practitioners do not understand how their day-to-day work can be empowering for their clients. At the heart of this role is the ability of the Practitioners to transform their own power (access to information, resources and expertise) to a power-with relationship in which their clients are helped to gain more power. The outcome is that individuals, groups and communities are helped to gain greater control over decision making and access to available resources in regard to public health issues. I discuss this in detail in Chapter 2.

One of the main tensions that Practitioners face in an empowering approach to public health practice is whether their clients actually want to be empowered. Public health practice is traditionally professionally led, for example, it is the Practitioner or the agency that employs them that selects the clients and the methods to be used in a programme. The initiation of the empowerment process and the enthusiasm for its direction is also often led by the Practitioner. This is contradictory to an empowering approach in which the issue to be addressed and the means of reaching an empowered solution are the responsibility of the clients and not the Practitioner.

Some clients may not want to be empowered. People, especially if they have lived in powerless circumstances, may feel that they do not have the right or do not possess the motivation to empower themselves. Likewise, some Practitioners may feel powerlessness in their own work setting and in Chapter 4 I discuss ways in which Practitioners can overcome powerlessness in a professional context. In addition, some individuals and groups such as the mentally ill or people with an addiction may not have the ability to organise and mobilise themselves towards empowerment. What must be remembered is that power cannot be given to people but must be gained or seized by those who want it. The right or choice to be empowered essentially rests with the individual or group and the role of the Practitioner is to encourage their clients to take greater responsibility and control over their lives. For those people who cannot or who refuse to take responsibility then public health practice may have to intervene and resort to other means, for example, policy and legislation, to protect the general population from the spread of an infectious disease.

In this book I argue that Practitioners can and often do play an important role in facilitating change in their clients, either on a one-to-one basis or through working with groups and communities, to take greater control of their lives. Practitioners, who are in a position of relative power, work to help their clients, who are in a relatively powerless position, for example, by providing resources and skills, education and advisory services and by using their professional influence to legitimise community concerns. To achieve this Practitioners must work with other professionals and agencies, both public and private, such as education, housing and social services, if they are to develop effective strategies. Public health is also a product of a global market and strategies must increasingly cross international as well as organisational boundaries.

Practitioners must be flexible in their approach to working with clients whose abilities and competencies may have to be developed. The Practitioner may be initially tempted not to involve their clients and may undertake the responsibility of planning and implementation. The reason for this is usually to ensure that programmes are in place in time to meet deadlines. Participation can be compromised and in the longer-term the programme has far less chance of success. The importance of participation can be illustrated by a programme with women's groups in a poor rural population in Nepal which led to a reduction in neonatal and maternal mortality. The women in the intervention clusters were found to have antenatal care, institutional delivery, trained birth attendance and more hygienic care and that this led to an improvement in birth outcomes. By participating in groups the women were better able to define, analyse and then, through the support of others, articulate and act on their concerns around child-birth. The advantage of participation was that it strengthened social networks and improved social support between the women and the providers of health services delivery (Manandhar et al., 2004).

People can therefore become involved in a meaningful way by taking part in decision making. The role of the Practitioner shifts to being an 'enabler', gaining the trust of and establishing common ground with their clients. This is crucial to

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the process of empowerment. Whilst Practitioners cannot be expected to have an influence on transforming power relationships across all sectors and at all levels of their everyday work there are two areas in which they do have an important role:

1. Practitioners are involved in influencing policies and practices that affect health, from national ‘down’ to the community level, for example, through their ‘expert’ power in meetings, technical advisory groups and committees. In order to influence policy and practice, Practitioners need to have a better understanding of the meaning of power and how their relationships with different clients are understood and appropriately acted upon by the profession. This is explained in Chapter 2.
2. In most democratic countries, the process of collective action is used to influence social and political changes through public, economic and regulatory policies. These changes are achieved through the legitimate action of individuals who use their decision-making power, for example, to vote. Practitioners, involved in their day-to-day work with individuals and groups, can help their clients to use their power-over decisions to have a greater influence over factors that influence their lives, including their health. To be more empowering in their work Practitioners need to have a clear understanding about the influence that they can have on the process of community empowerment when working with individuals, groups and communities and this is discussed in Chapters 4, 5 and 6.

In practice, an empowering approach to public health involves helping individuals, and the groups and communities in which people participate, to gain power. It also means helping individuals to increase their control over the decisions which influence their lives and their participation in groups and organisations that share their concerns. Participation in interest groups and organisations is the first step for many individuals towards community action. In turn, a collective and more organised context, such as community-based organisations, provide the Practitioner with the opportunity to more effectively help others to increase their knowledge, skills and competencies.

■ The evolution of empowerment in public health practice

Empowerment is defined here as a process by which people are able to gain or seize power (control) over decisions and resources that influence their lives. In the United Kingdom, for example, this concept evolved in public health as an important ideology in the mid-nineteenth century. The political liberalism of the Victorian period led to the creation of many pressure groups, such as the Health of Towns Association, with a concern for equity and social justice. These pressure groups, with the assistance of key public health reformers such as Edwin Chadwick were active in mobilising the middle classes who in turn had an influence on the press and on the government. This is called the ‘sanitation phase’ and was a

period that through both influential reformers and collective action resulted in the government passing key public health legislation such as the 1833 Factories Act and the 1848 Public Health Act (Baggott, 2000). However, these actions were also influenced by the desire of the government to reduce their own responsibilities and to improve the efficiency of the nation's workforce. Public health reform was as much due to the discourse of economic production as it was to the discourse of empowerment and to good governance. During the second phase, occupying the first half of the twentieth century, the growing status of the medical profession added to the political influence of the public health lobby. Consequently, the emphasis was on a public health dominated by a bio-medical model and a focus on the absence of disease and illness.

It was not until the 1960s and 1970s that empowerment became part of the discourse stemming from a growing body of 'new knowledge' that sought to challenge conventional thinking. Within public health, the discourse also broadened from the bio-medical model to include a behavioural and lifestyle component. The main reasons for this change in thinking were an increase in the role of chronic degenerative diseases such as heart disease as the leading causes of morbidity and mortality. These chronic diseases involve the interplay of different factors or determinants over time such as smoking, lack of exercise and a poor diet and have become synonymous with a healthy lifestyle. However public health, at the time closely associated with health education, placed an emphasis on the responsibility of the individual and on a 'victim-blaming' philosophy rather than on collective action and social equity. Internationally, the need for social justice in the challenge to improve health was increasingly recognised and became the subject of professional discourse, for example, the 30th World Health Assembly, held in Geneva in May 1977, which set the target of health for all by the year 2000. The following year, an international conference on primary health care in Alma Ata in the former USSR endorsed this and strongly affirmed the WHO's positive definition of health (World Health Organisation, 1986), noting that it was a fundamental human right. The Alma Ata Declaration of 1978 recognised that the gross inequalities in the health status between and within countries was unacceptable and identified primary health care as the key to attaining health for all by the year 2000. The Declaration recognised that people must be actively involved in the process of development and states: 'The people have the right and duty to participate individually and collectively in the planning and implementation of their health care' (World Health Organisation, 1978, p. 1). The declaration goes beyond participation to imply that empowerment is a necessary component to primary health care and public health.

The Alma Ata Declaration does not use the term empowerment but many of its points imply involvement by individuals and the community. This is in part a reflection of the discourse in the early 1970s when the concept of empowerment had not become fully legitimised. The concept of community participation was viewed as a means to target people as beneficiaries of development by involving them in the process. The discourse argued that participation would allow local knowledge and needs to be incorporated into a programme and would give the

people more control in decision making. In practice, this depends on the power relationships between Practitioners and their clients. If Practitioners use their power to take a paternalistic stance, it can lead to community coercion over programme planning and implementation by an outside agent.

Since the early 1980s there has been a shift within public health towards empowerment and community participation embodied in the socio-environmental approach (Robertson and Minkler, 1994). This shift was guided by key strategic documents, such as the Ottawa Charter for Health Promotion (WHO, 1986) and the Bangkok Charter for Health Promotion in a Globalised World (WHO, 2005), but was also due to other contributory factors of a social nature. One of these factors was an increased awareness of growing inequalities in health status between different social groups and the narrowness of the focus on individual behaviour that ignored the psychosocial and physical environments, community and culture. It was recognised that the individualistic nature of public health education campaigns did not recognise the social and environmental contexts in which personal behaviours are embedded and which were important health determinants. Another significant factor was the maturing of many pressure groups and social movements such as the environment movements, the gay rights and Health Social Movements, who challenged the notion of the medical and behavioural approaches to health and raised concerns for social justice and environmental sustainability (Freeman, 1983). The role of Health Social Movements in public health is discussed in Chapter 5.

■ Power and public health practice

□ A bureaucratic setting

The public health profession provides a network of Practitioners that dispense 'expert' advice and services largely through bureaucratic settings. A bureaucratic setting consists of a number of distinctive positions of control (power) with specialist duties that are usually formally defined. The officials who hold these positions of power are recruited according to specific rules and their employment is usually based on a system of salaries. Power is hierarchically top-down and the official is expected to act in accordance with, and without challenging, the instructions descending from their superiors (Turner, 1995). Examples of highly bureaucratic and hierarchical public health organisations include government departments and hospitals. Positioning oneself within the hierarchy of a bureaucratic setting provides a professional legitimacy and status. This is achieved not necessarily because that person has particular expertise but because the institutionalisation of the position creates the idea that she/he is an expert. Within bureaucratic settings Practitioners can however be attributed more occupational autonomy over the process by which a particular service is delivered, for example, individual nurses who did not have to seek approval for every action were found to act more autonomously than on a closely managed ward (Kendall, 1998, p. 25).

□ The hegemony of the medical profession

The rise of the medical profession has been successful in maintaining its position of dominance within the public health bureaucratic hierarchy by controlling access to health care delivery. This has been termed the ‘hegemony of the medical profession’. Hegemonic power is a form that is invisible and internalised such that it is structured into our everyday lives and taken for granted (Foucault, 1979) and is discussed in more detail in Chapter 2. The medical profession has formed itself as a powerful professional pressure group both as a collective work force and through key associations, for example in the UK, the British Medical Association and the Royal Colleges. The medical profession, although not a complete monopoly because of the growth of other health professions, has been granted considerable control to maintain self-regulation and clinical autonomy in their work. In fact, the dominance of the medical profession has been blamed for the historical subordination of the nursing profession and a key challenge to nurse empowerment (Kendall, 1998, p. 33). Much of the power held by the medical profession is also supported by the public who expect confidentiality in the special relationship that they hold with their doctor. The medical profession is also dependent on various alliances with other health professionals, the government, the private sector, science and activists in civil society. It has been careful to create an alignment between both professional and public interests, for example, in regard to the under-resourcing of the UK National Health Service, long waiting times for treatment and the unacceptable demands placed on hospital staff. This professional dominance has also been paralleled with an increase in the legitimacy of medical knowledge, urbanisation, the expansion of health insurance and the growth of bureaucratic settings such as hospitals as centres for ‘professional excellence’ (Turner, 1995). However, there have been challenges to the expert wisdom of medicine from, for example, through the Health Social Movements and lay epidemiology.

□ Lay epidemiology

Lay epidemiology is a term that has been widely used to describe the processes by which people in their everyday life understand and interpret health risks (Allmark and Tod, 2006). To reach conclusions about the risks to their health they access information from a variety of sources including the mass media, the internet, friends and family. Lay epidemiology presents a challenge to the accepted ‘wisdom’ of public health in at least two ways:

1. People through reaching their conclusions do not necessarily accept health messages. People have recognised that some health messages are ‘half truths’ and this is further confused by the changing of some messaging, for example, in regard to safe limits for alcohol consumption. The prevention paradox is that targeting the behaviour of the majority who are at a low to medium risk has little effect at the individual level. For example, reducing dietary fat

consumption for the whole population would reduce coronary heart disease but it is difficult to change the behaviour of those whose risk is only low to medium. Practitioners have therefore chosen to use simple messaging that does not tell the whole truth by exaggerating the risks of a particular behaviour or the benefits of changing that behaviour. A reliance on health education approaches has led to mistrust in the public and when people feel that the risk does not apply to them, a rejection of the advice (Hunt and Emslie, 2001; Rose, 1985);

2. People also have cultural and personal values that undermine the meaning of health messages, for example, a person can choose not to give up smoking simply because it may be damaging to their health when they believe that the benefits of smoking such as pleasure and reducing stress, outweigh the risk. People can view any particular health behaviour in at least three ways: 1. It is bad because it is poisonous 2. It is bad but desirable such as drinking alcohol 3. It is bad in some ways but good in others such as smoking. People's perception of risk therefore depends on their circumstances, culture and values and an 'all things considered' approach is taken. This is in contrast to traditional epidemiology which is purely empirical (Allmark and Tod, 2006).

Lay epidemiology is the basis for many empowerment approaches. As I discuss in Chapter 3, the empowerment element of a programme is based on the concerns of the community. Communities are influenced by the information that they receive from the many, and sometimes conflicting, sources and that they feel can place them at risk. For example, in the UK public concerns were raised about the MMR (Measles, Mumps and Rubella) vaccine. The public health authorities saw this as an effective option with few side effects. However, following media reports of conflicting scientific evidence the public became increasingly concerned that the vaccine could lead to bowel disease and autism. These concerns were further confounded by past distrust between the authorities and the public over the handling of 'mad cow disease' (Bovine Spongiform Encephalopathy or BSE) and conflicting evidence on the benefits of screening, for example, the benefits of mammography (Smith, 2002). Attempts to coerce or manipulate the public can mean that lay epidemiology becomes a pathway for the community-based actions of a dissatisfied public that lead to collective empowerment.

The public health view has historically been the unquestioned truth. But in an increasingly postmodern world there is no 'truth' whether defined by public health or any other experts. There are different opinions based on different views and theories none of which hold an absolute truth. Lay epidemiology poses a threat to public health because it challenges the accepted wisdom which then is no longer the dominant perspective. Of course, the means of governing people, governmentality, is dependent on 'expert' systems of knowledge, science and empirical truths. This is the means by which to regulate how professionals are empowered to control health care, knowledge and a variety of social problems that do not necessarily fall within the bio-medical sphere. The authority structures in regard to health are part of the power-over that the state has on society (Brown and Zavestoski, 2004).

The public is open to rational discussion and Practitioners are right to engage with communities to offer advice that is based on sound scientific evidence. Public health experts have therefore played an important mediating role between those in authority and individuals and social organisations by helping to shape their daily conduct through rationality and self-regulation. Public health provides a measure of the well-being of populations, documenting and establishing trends based on its 'expert' and 'legitimate' power. This sets standards of 'normality' that can be compared in relation to other population groups. In this way, public health practice can build upon political concerns and create issues that they show can be overcome by using their 'expert' knowledge and power. Public health becomes a coercive and manipulative way to influence the way people think and act (Lupton, 1995). This is not always intentional on the part of the Practitioners who face the challenge of meeting targets based on empirical, bio-medical outcomes and which the public may not be ready or willing to engage with. The danger is that public health can present an illusion of greater individual and collective choice whilst acting to hide an agenda that intends to control others to do what we as professionals want them to do, even against their will. Public health then becomes the very opposite of an empowering practice.

Using professional power in public health

If it is true that public health is a bureaucratic activity, carried out by or within governmental organisations or government funded agencies, it is also true that many of these organisations remain chained to traditional ways of thinking and acting, ways which inhibit the effective inclusion of empowering approaches. Various studies of both government and NGO agencies have found that the concept of empowerment used in policy and in practice are often quite different. Despite the intent to 'empower' communities, the organisations and their staff tended to retain control over programming rather than to relinquish power to others. The agencies operated within a contradiction between discourse and practice; many Practitioners continued to exert power-over the community through top-down programming whilst at the same time using an emancipatory discourse (Grace, 1991; Turbyne, 1996).

To build a more empowering practice, public health must redress the constraints placed on the profession by its bureaucratic nature and by other associated professional health groups who do not share an ideology of empowerment. As I discuss in Chapter 2, before Practitioners can empower others they must first be themselves empowered and understand the sources of their own power. This has been argued in the context of a nursing profession that cannot be empowered unless individual nurses themselves are empowered and can be extended to a bureaucratic work setting such as a hospital; a community of both patients and staff. Both must be empowered and this includes feeling valued and having the resources, skills and knowledge to empower others (Kendall, 1998, p. 14).

But governments and the bureaucracies that they create, at least in democratic countries, are not monolithic entities. Not only are there often contradictions

between the policies and actions of different government agencies but different Practitioners with differing ideas often exist and work together. Practitioners working in large bureaucratic settings can find their professional autonomy being undermined by the hierarchical structure of rules and lines of control. Professional groups can also become fragmented into sub-groups or else their power base is encroached upon by para-professional groups. These circumstances actually present opportunities for an empowering practice to develop within even the largest, most rigid bureaucracies. To take advantage of these opportunities public health agencies must understand how to address imbalances in the power relationships in their structures and systems at all levels from the top tiers of policy and planning 'down' to the people working at the interface with the community. It is precisely this type of a fundamental issue that must be addressed if Practitioners are to engage an empowering approach in their daily practice. In a professional context the key question is: Do Practitioners *really* want to help to empower people or to simply change their behaviour? The latter has traditionally been the most popular choice and the difference between an empowering approach and a coercive approach has been in the method used. If the method is directive, top-down and controlled by an outside agent it is less likely to be empowering. If it facilitates a process of problem identification and actions based on the concerns of the individual or community and uses capacity building strategies it will have a much better chance of being empowering. Practitioners must make the decision to empower themselves, to gain the necessary skills and knowledge, if they are really committed to an approach that will empower others. Empowerment approaches are also dependent on funding and on there being a political will to implement them. This may be problematic when the goal of the people who are involved in community empowerment is to bring about a change in the political order and to challenge the very agencies that fund and support their continuation. This can create an untrusting relationship between formal agencies and the community. It is a power relationship that must be equalised and which is a central theme of this book.

■ Public health practice and the interpretation of health

The multiplicity of meanings assigned to public health is also a function of the multiplicity of meanings assigned to our understandings of health. In particular, it is useful to consider the distinction between official understandings, those used by public health professionals, and lay understandings, the more popular perceptions held by those who are usually the recipients of health interventions, the public. Practitioners have largely used official interpretations because these are easier to define and measure, rather than lay interpretations of health, which are subjective, being based on the experiences of the individual. In particular, the biomedical interpretation of health has established itself as the most dominant official interpretation. It is the medical profession, which has been the champion of this model of health, based on the absence of disease and illness, and upon which other

health professions have modeled themselves including the field of public health and nursing.

The bio-medical model evolved as a result of scientific discoveries and technological advances in the eighteenth and nineteenth centuries and this led to a greater understanding of the structure and functioning of the human body. As knowledge and understanding about the functioning of the human body increased, health took on an increasingly mechanistic meaning. The body was viewed as a machine that needed to be fixed. A professional split between the body and mind developed, the body and its physical illness was the responsibility of physicians while psychologists and psychiatrists looked after the psyche and its illnesses. However, the focus remained on the external causes of ill health and was reinforced by the constant threat of disease and death from epidemics such as polio and scarlet fever (Laverack, 2005).

Peter Aggleton (1991), a commentator on public health issues, divides the official interpretations of health into two main types: those, which define health negatively, and those, which adopt a more positive stance. There are two main ways of viewing health negatively. The first equates with the absence of disease or bodily abnormality, the second with the absence of illness or the feelings of anxiety, pain or distress that may or may not accompany the disease. Aggleton points to the importance of recognising that some people may be diseased without knowing it. People are unaware of their illnesses until they start to suffer pain and discomfort, when the person is said to be ill. Negative definitions of health emphasise the absence of disease or illness and are the basis for the medical model. A number of problems have been raised concerning the negative definition of health. In particular, the notion of pathology implies that certain universal 'norms' exist against which an individual can be assessed when making a judgement as to whether or not they are healthy. This assumes that such standards actually exist in human anatomy and physiology.

Positive interpretations of health have also been widely used by health professionals. The first modern positive definition of health came in 1948 when the World Health Organisation (WHO) stated that health was 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity' (Jackson et al., 1989). Physical well-being is concerned with concepts such as the proper functioning of the body, biological normality, physical fitness and capacity to perform tasks. Social well-being includes interpersonal relationships as well as wider social issues such as marital satisfaction, employability and community involvement. The role of relations, the family and status at work are important to a person's social well-being. Mental well-being involves concepts such as self-efficacy, subjective well-being and social inclusion and is the ability of people to adapt to their environment and the society in which they function. The WHO definition has become one of the most influential and commonly used in public health and for that reason its origins, which are set in the context of empowerment, are worthwhile exploring in Box 1.1.

The WHO definition of health, as an ideal state of physical, social and mental well-being has been criticised for not taking other dimensions of health into

Box 1.1 The Origins of the WHO Definition of 'Health'

The WHO definition was written soon after the Second World War by an official who had spent his time working in the Resistance. He had come to this definition from his experience and explained that he had never felt healthier than during that terrible period: for he daily worked for goals about which he cared passionately, he was certain that should he be killed in his dangerous work, his family would be cared for by the network of Resistance workers. It was under these circumstances that he felt most healthy, most alive. The definition of health was developed by a person who was passionately involved with others to change social and political structures. In other words, they were involved in taking control over those things which affect their lives and by doing so empowered themselves and improved their own health and well-being as well as that of others with whom they associated (Jackson et al., 1989).

account, namely the emotional and spiritual aspects of health (Ewles and Simnett, 2003). The definition has also been criticised for viewing health as a state or product rather than as a dynamic relationship, a capacity, a potential or a process and does not clarify how to define or measure its components.

The way in which people interpret the meaning of their own health is a personal and sometimes unique experience. Health is a subjective concept and its interpretation is relative to the environment and culture in which people find themselves. Health can mean different things to different people. Many people define health in functional terms by their ability to carry out certain roles and responsibilities rather than the absence of disease. People may be willing to bear the discomfort and pain of an illness because it does not outweigh the inconvenience, loss of control or financial cost of having the condition treated (Laverack, 2005).

This subjective view of health raises the issue of radical relativism which maintains that the only 'true' reality is the unique experience of the individual. Whilst it is important to understand individual feelings and experiences about health there may be others that are common to particular groups. Inter-subjectivity is a concept used to overcome the limitations of radical relativism. It claims that any given person's understanding of the world is unique but because it is constructed from a field of more or less common social meanings and experiences, communication between people is possible. In other words, the meanings we create of our own experiences, for example of health, overlap sufficiently so that we can communicate and share these with others. The importance of personal interpretations of health is becoming increasingly well recognised, for example, the link between individual control and health has been demonstrated in several studies (Brunner, 1996; Everson et al., 1997). Everson et al. (1997) undertook a study of Finnish middle-aged white males and concluded that stress induced from job demands

and feelings of a lack of control was the strongest predictor of arterial heart disease. A review of heart health inequalities in Canada found that people who experience low income, less control in their lives and at work and who had a poor education are more likely to experience morbidity and mortality. In other words, the higher one's position in the workplace or society, one's power (control), wealth and status, the better one's health and sense of self-esteem (Labonte, 1993).

Self-esteem is actually a social phenomenon and not an individual creation. A person's self-regard and sense of coherence is not grounded in 'the self', but in relation to friends, family, colleagues, the communities and settings in which they live and work. Social support is therefore also generally accepted as having a beneficial effect on health, both at home or in the community; for example, by sharing problems people are better able to cope with stressful events. Social support is connected to other similar overlapping concepts such as social capital, social inclusiveness, social exclusiveness and social cohesion. These concepts fundamentally address a sense of connection to a 'community' and the involvement and trust between its members manifested through customs, rituals and traditional groupings such as weddings.

Official definitions of health can differ significantly from lay definitions but both are ideal types and in practice coexist and inform one another. Practitioners have embraced a discourse that uses an official definition that goes beyond health care and lifestyle to feelings of well-being. Health is considered to be a means to an end that can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. However, in practice, public health programming has increasingly been concerned with accountability to funders, effectiveness and value for money (Boutilier, 1993). Budgetary constraints, competition for funding and priorities for health have also had a strong influence on the way in which health has been interpreted. The public health profession has taken the pragmatic view that whatever interpretation of health is used it must be measurable and accountable, otherwise programmes employing its ideology and strategies will be in jeopardy of being unable to justify their economic and quantifiable effectiveness. This being the case, the measurement of health has focused on the bio-medical approach that is concerned with demonstrating a relationship between a health status measure and a behaviour such as smoking or a condition such as mortality. The boundaries for public health practice and discourse have consequently been defined by the interpretations of illness and disease rather than by the way in which most people generally view their own health.

Next in Chapter 2, I move the reader into the territory of how power, as a concept, is central to public health practice; what power looks like; what the means to attaining power is and how Practitioners can act to transform personal and social power relationships at the individual, group and community levels.

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