COMMUNITY PARTICIPATION IN HEALTH

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"The next few decades are crucial. The time has come to break out of past patterns. Attempts to maintain social and ecological stabilty through old approaches to development and environmental protection will increase instability. Security must be sought through change."

from "Our Common Future",
Report of the World Commission
on Environment and Development, 1987,
(the Brundtland Report).

Purpose

The purpose of this paper is to explore some ideas about community participation that I hope may be of some use to you as activists in the Healthy Cities movement.

I am presently working in Canberra but my ideas owe a great deal to my experience with district health councils and community health centres in Victoria and in particular to my colleagues in the Community Development in Health Project[1] in Melbourne.

Levels of Participation

Community participation is not a precise term. It could be taken to encompass a wide range of different degrees of participation; so wide as to make any general discussion meaningless. I shall illustrate with two examples.

The local community health centre organised a concert under the Rage Without Alcohol banner and lots of young people came, and participated and enjoyed themselves. Is that community participation? It certainly involved quite a number of young people, but in a relatively passive and ephemeral way.

The tenants' group in a local public housing estate, got together with a local community health worker in order to develop a proposal for a food cooperative in their block. This is also community participation but in this latter case the "participation" is more active and more deeply engaging.

These examples illustrate two different levels of participation; let's call them *passive and ephemeral* compared to *active and engaged*.

This is not a simple dichotomy. Community participation which aims to be active and engaged must encompass the possibility of participation at lesser degrees of engagement, including relatively passive or ephemeral participation. The converse does not hold. If participation is modelled around the more passive and ephemeral kind it clearly does not encompass a more deeply engaged participation.

The principles involved and the implications of these two different levels of community participation are really quite distinct.

The various official papers associated with the Healthy Cities movement, point clearly to the importance of encompassing the more active and engaged end of the spectrum and I propose to spend some time discussing why this should be so.

Two Approaches to Health Promotion

I think that it would be useful to start by recognising two different approaches to health promotion.

Kickbusch[2] has described these as the *risk factor - disease prevention approach* and the *ecological health promotion approach*.

The risk factor - disease prevention approach is based on tracking through the specific causal relationships between the specific disease processes, various risk factors and particular environmental conditions. Disease prevention initiatives are designed to break these causal links. Fluoridation and immunisation are good examples.

The ecological approach starts from the premise that the various diseases and risk factors are all part of a single social ecosystem, ultimately part of a global ecosystem. Patterns of disease and the prevalence of risk factors are understood in system terms. Interventions are evaluated in terms of their impact on the whole system and are aimed at shifting the whole system towards a healthier equilibrium position.

This is not a simple dichotomy, between the risk factor approach and the ecological approach. The understandings derived from risk factor research constitute an integral part of the ecological approach but the reverse is not true. Those who limit their analysis to the specific causal linkages between particular diseases and particular risk factors are not making use of the insights of the ecological approach.

So what does this mean in terms of community participation? Well, it depends on what sort of role community participation plays within the model that you are working with.

Those who work entirely within the risk factor - disease prevention model tend to view community participation primarily in instrumental terms. Community participation is seen as a strategy for encouraging behaviour change or as a way of generating community support for particular improvements in the environment.

I offer two illustrations:

Fun events are run every year at the beach aiming to emphasise the dangers of excessive sun exposure, to challenge the influence of bronze-is-beautiful body images.

Local sporting teams are sponsored by Quit aiming to change the climate of public opinion in relation to smoking, partly to discourage individuals from taking up smoking but also as part of building a community constituency to support the progressive elimination of tobacco promotion.

In both cases, community participation is conceived primarily in instrumental terms.

The ecological analysis is fully consistent with the need to challenge unhealthy body images and to build community support for healthy public policy. However, it might approach these needs from a different perspective.

A useful way of getting to grips with the ecological approach to health promotion is to enquire into the health gap; the inequalities in health outcomes and in health experience across race, income, social class and gender.

(insert Table 1, from Marmot, Kogevinas and Elston[3], around here)

Table 1 Birthweight and mortality in England and Wales by social class.[a] Morbidity and health behavior in Great Britain by socio-economic group[b]

		Social class[a]					
		I	II	IIIN	IIIM	IV	V
Birthweight ≤ 2500 g, 1980(%)[c,e]		5.3	5.3	5.8	6.6	7.3	8.1
MORTALITY[c,d]							
Perinatal mortality/1000 [e], 1978–1979		11.2	12.0	13.3	14.7	16.9	19.4
Mortality 1–14, 1970–1972[e] (SMR)	M	74	79	95	98	112	162
	F	89	84	93	93	120	156
Maternal mortality, 1970–1972[f] (standardized maternal mortality rate)		79	63	86	99	147	144
All cause mortality 15–64, 1970–1972 (SMR)	men	77	81	99	106	114	137
	married women[f]	82	87	92	115	119	135
	single women	(110)	79	92	108	114	138
Coronary heart disease, men 15–64, 1970–1972 (SMR)		88	91	114	107	108	111
Diseases of respiratory system, men 65–74 (PMR)		60	74	82	105	108	123

		Socio-economic group[b]					
		1	2	3	4	5	6
MORBIDITY[g] (age 45–64)							
% reporting long-standing illness	M	35	31	41	42	47	52
	F	32	36	40	41	49	46
Avr. no. restricted activity days per person per year	M	4	14	30	31	27	38
	F	22	23	28	27	33	39
HEALTH BEHAVIOR[c,h]							
Prevalence of cigarette smoking, 1984	M	17	29	30	40	45	49
	F	15	29	28	37	37	36
Participation in active outdoor sports (%), 1977	M	42	34		23	17	15
	F	30	27		17	14	11

(These are actually UK data but comparable figures have been documented in Australia and in many other countries.) In respect of every indicator listed in this table, of mortality, morbidity and health behaviour, there is a clear relationship to social class and socio-economic status.

I am sure that you are familiar with similar figures in relation to Aboriginal health in Australia.

How shall we understand the differential mortality and the differential prevalence of known risk factors by social class and by race?

Following a comprehensive review of the relevant literature, Lindheim and Syme[4] in 1983 concluded:

"*(W)e have found increased rates (of disease) to occur when:*

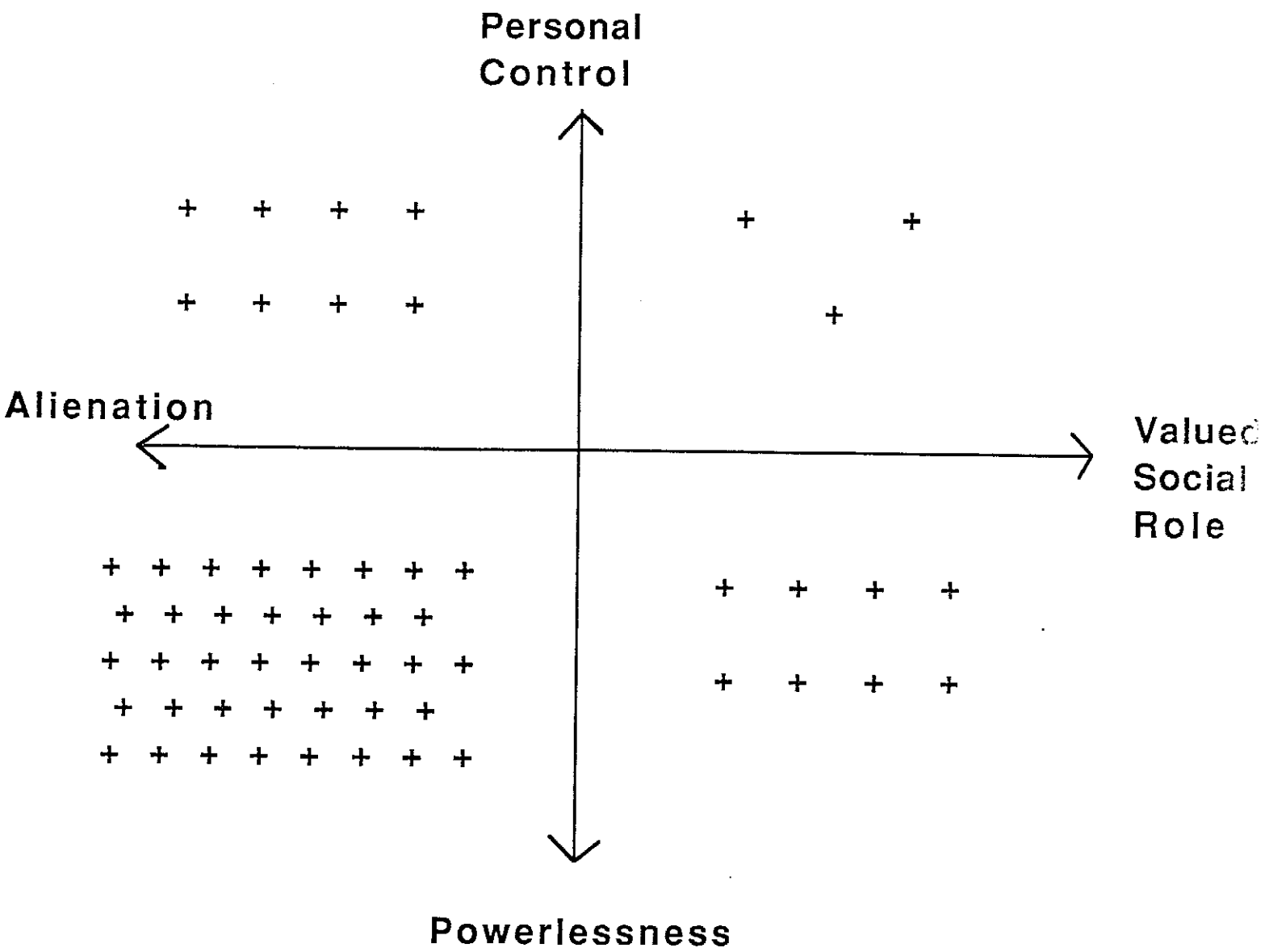
(a) supportive ties between people are interrupted,

(b) people occupy low positions in a hierarchy, resulting in feelings of low self-esteem, less opportunity for meaningful participation and less control over the conditions affecting their lives, and

(c) people are disconnected from their biological, personal and historical past."

The Community Development in Health Project in Melbourne has worked with a slightly simpler formulation, which is basically consistent with these findings.

(Insert Figure 1 around here)


Personal
Control
Alienation
Valued
Social
Role
Powerlessness

CDIH

According to this view, inequalities in health can be understood in terms of personal control (as opposed to relative powerlessness) and valued social role (as opposed to alienation).

> *At the most basic level poverty denies you access to resources and protections necessary for good health: adequate diet, a heathy living environment, a safe working environment and appropriate health care.*

But it goes deeper than this.

> *The message of much health promotion is along the lines of: 'act now and you will be healthy later'. However, many people's experience is that no matter how much effort they put into acting now for their future benefit, in fact, they find themselves swept along by greater forces. If one's experience is of having not much control over one's life, then 'act now, on the expectation of being healthy later' does not apply.*
>
> *Another way of looking at this is in terms of the balance between the demands upon you, on the one hand, and your resources and capacities on the other. If one's current life pressures include unemployment and the threat of eviction, for example, then the future benefits of struggling to give up smoking would not justify a high priority for most people.*
>
> *The experiences of individuals of trying to control their life (and health) or of balancing health priorities against other pressures and needs, feed into the expectations that prevail within the different subcultures of our community.*
>
> *In subcultures in which it is a common experience that people do not have much control over their life directions or that their coping resources are fully committed to immediate priorities, these experiences become the common expectation within that subculture. In such circumstances changing one's behaviours in the expectation of future health benefits is less likely than it might be otherwise.*

A similar pattern is evident in relation to alienation versus having a valued social role.

> *The need to belong usefully is denied to many people in our community. The message of uselessness is given clearly in the experience of school failure and youth unemployment and in the idleness of mandatory retirement. The need to belong usefully is denied when the structure and context of people's work is so alienating that it is an experience of exploitation rather than contribution.*

> *It is somewhat contradictory to expect people to place a high priority on looking after their health if they are subject to parallel messages to the effect that they are not really worth looking after.*[5]

If you understand health promotion in these terms, an exclusive focus on specific risk factors and the prevention of specific diseases seem a bit problematic. Initiatives aimed at specific behaviours or aimed at specific environmental improvements may lead to improvements in those specific conditions whilst leaving the basic pattern unchanged.

And this, of course, is the case historically. Whilst the disproportionate incidence of cholera among poorer people may have been reduced by the provision of fresh water and sewerage and by health education about hand-washing, the overall mortality differential between social classes is as wide as ever, perhaps wider. The specific diseases and risk factors which mediate such inequalities have changed; the existence of health inequalities has not. Change but no change.

If powerlessness and alienation play significant roles in mediating the observed inequalities in health then we need to look towards initiatives and programs which, *as well as addressing specific behaviour change and instrumental policy changes, also addresses the underlying issues of powerlessness and alienation.*

This is perhaps the defining characteristic of the community development approach to health promotion; that, as well as addressing the specific issues associated with diseases and risk factors, such initiatives are undertaken in ways which are empowering and community-building.[6]

Quite clearly, community participation needs to be of a quite different order if we are expecting that the experience of participating will be empowering for less powerful people; that the experience of participating will be personally and collectively affirming for people who have been, in some degree, alienated and marginalised.

Learning from the Aboriginal Health Movement

Aboriginal communities in Australia have had a lot of experience of health promoting experts coming in from outside and recommending specific behavioural changes or environmental improvements which are seen as necesary in order to overcome identified risk factors ranging from glue sniffing to poor sanitation.

The effectiveness of such programs, introduced in isolation and controlled by the outside experts has generally been dismal.

The community-controlled Aboriginal health services have strongly opposed this sort of one dimensional aproach. They have emphasised that the health of Aboriginal people can't be separated from the social and economic circumstances of their community generally, most importantly their dispossession from their land. They have emphasised that health promotion initiatives must be developed and implemented in accordance with their priorities and controlled by their communities.

In these circumstances, the experience of planning and implementing each new program (whether it be aimed at glue sniffing, or diabetes control or diarhoeal disease) will at the same time contribute to the growing strength and confidence of that community.

The Aboriginal example illustrates the general rule. Within the ecological approach to health promotion community participation is seen as developmental rather than instrumental.

Community Development

I propose to comment briefly on some of the implications of this concept of "developmental" participation.

Community development cannot be commodified or engineered. An integral part of community development is personal growth, reflecting and causing concurrent cultural and social change. Personal growth starts from where people are at; it can't be prescribed by outsiders.

Community development does not deliver narrowly determined instrumental goals. Respect for community priorities is a necessary condition for real partnership between health agencies (or civic agencies) and the communities with which they wish to work.

There must be a significant degree of real control exercised at the community level; manipulation is disempowering and anti-health no matter how well intentioned.

There is a great deal more which could be said about community development and "developmental" participation. I would refer you to the work of the Community Development in Health Project in Melbourne as a useful starting place.

I talked earlier about alienation and powerlessness from the perspective of people who are relatively powerless or alienated.

But I should emphasise that the underlying priniciples do not just apply to identified disadvantaged groups. Alienation and powerlessness are matters of degree. In different degrees, the same relationships can be demonstrated throughout society.

People and communities who are relatively powerless are going to find it that much more difficult to achieve healthy working environments and living conditions and to move towards healthier lifestyles. People who are, in some degree alienated from the mainstream, are that much less likely to find the resources needed to reduce their alcohol use or to advocate for bike paths.

If health promotion is to address the underlying, structural causes of ill-health then it calls for community participation which is *developmental not instrumental*, which is empowering and community building as well as addressing specific risk factors and policy advocacy.

Health Promotion or Sedition?

I should acknowledge that much of the Healthy Cities rhetoric actually alludes to these ideas but usually in fairly oblique terms. Perhaps that is not so unreasonable.

Land rights and self determination may be the key health promotion strategy for Aboriginal communities but it was the strong opposition of the mining and pastoral interests in West Australian that discouraged the Federal Government from proceeding with its national land rights program.

The obverse of poverty is wealth. Does the recognition of poverty as a risk factor threaten the security of those who are wealthy. Does the recognition of unemployment as a health hazard threaten the rights of business to hire and fire. Can Australia's export competitiveness accommodate a recognition of the health effects of alienation and powerlessness?

Healthy Cities aims to speak to a universal audience. Is there a contradiction between recognising and addressing the structural causes of ill-health and building a wide coalition of support within Healthy Cities?

The answer to all these questions is, of course, yes ... and no.

Of course poverty is the obverse of wealth. Of course the replacement of labour by automation has implications for the employer which are different from those for the retrenched employee.

But let us explore the alternative options from the point of view of the more affluent and advantaged sections of our society.

They may well argue against the social context analysis, against the ecological analysis of health, against using a community development approach in health promotion.

They may well argue for the narrower (and safer) risk factor based disease-prevention approach. They may insist on understanding community participation in instrumental rather than developmental terms.

That is their right (and there are some powerful advocates of just this position).

But in private they should be willing to acknowledge that, even the most high profile risk factor campaigns, will not contribute to reducing inequalities in health because they do not address health promotion, in ecological terms, in its broader social, economic and cultural context.

In times gone past there were no real barriers to the rich people and the rich countries pulling up their drawbridges and leaving the *sans cullottes* outside to starve. Indeed this is what the rich world is doing to the Third World today, literally.

However, as we near the turn of the millenium there are real doubts as to whether this winner-take-all strategy is still a goer.

Global Limits

The biosphere may be nearing its limits with respect to accommodating humanity's appetite for consumption. The threat of global warming, the loss of top soil, the ozone hole, the loss of biological diversity, the impact of drift net fishing, the destruction of forests: these are some of the signals that Mother Gaia is reaching the limits of her tolerance.

The Brundtland Commission, which I quoted at the begining of this paper has sketched the kind of industrial and cultural changes that we will need to make if we are to stabilise the global population and move towards an ecologically sustainable relationship with our environment.

These changes will require global cooperation and sharing, the building of trust and collaboration, within cities as well as within and between nations.

It seems to me that perpetuating the polarisations and the tensions between the haves and the have-nots, in our cities as well as nationally and globally, is not compatible with addressing the agenda set out by the Brundtland Report.

The have-nots will be unable to collaborate in restructuring our culture and the way we relate to our environment because they are too preoccupied with the day to day survival pressures which they face.

The haves will be unable to collaborate in restructuring our culture and the way we relate to the environment because they are too preoccupied with their fears and insecurities, and the need for more protection.

The kind of social and global polarisation that is identified with the policies of Thatcher and Reagan will ensure that the survival struggles of the poor and the insecurities of the rich continue to take precedence over cooperating in the development of new cultures and new ways of doing things globally, nationally and in our cities.

In short, the winner-take-all scenario will actually take us all down the plug hole.

Win Win Outcomes?

The outlook may not be so bleak. Perhaps the win-lose or lose-win scenarios are not the only options.

It may be that there is also a win-win option but one which entails a rethinking of some of the basic values of our cuture.

If, as a culture, we are able to think beyond the economic necessity for selfishness, material possessions as fulfillment and the extremes of individualism, then we might be looking towards a win-win scenario in which the affluent and disadvantaged both gain; security without control, fulfillment without materialism, individualism tempered by a sense of belonging to a sharing and supportive community.

There are grounds for believing that this cultural change is already starting to take place.

The women's movement has had a strong influence over the last three decades, challenging the dominant place that values such as competitiveness and maintaining control have previously occupied in our culture.

The women's movement may also provide us with a model of a win-win outcome. In the course of adapting to the demands of the women's movement, many men have learned new ways of understanding themselves and of conducting their relationships and have no regrets for that which they may have lost.

The growing political power of the Greens has also demonstrated a widening concern for curbing our materialism and consumerism.

It may be that the Healthy Cities movement is also part of these developments. Indeed, if Healthy Cities is informed by an ecological understanding of health; if there is meaningful community participation, conceived in developmental terms and speaking to the whole community, then Healthy Cities must make an important contribution, not just to better health but to building an ecologically sustainable world.

References

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