4
Working to Build Empowerment: The Local Challenge

Before examining how the global now suffuses the local, Chapter 4 discusses the empowerment challenges that are faced at a local level. Many of these challenges apply to global mobilising as much as they do local empowerment. Five key steps that health promotion programmes should take into consideration are addressed: (1) engaging with people to address local concerns; (2) building local partnerships; (3) building community capacity; (4) influencing health policy; and (5) evaluating local empowerment.

The local empowerment challenge is to initially create sufficient support for a particular concern in order to form a 'community of interest' or 'interest group'. This community and its members then embark on a process (referred to as an empowerment continuum in Chapter 3) towards gaining more control over the decisions that influence their concern. This may be in regard to resource allocation such as the award of a grant, or to decision-making such as the development of policy or legislation.

Engaging with people to address local concerns

Engaging with people is a collaborative process, often between an outside agency and a 'community', a term we use in quotes to remind readers of its plural meanings and dimensions discussed in Chapter 2. This is not a straightforward process. For example, research in the UK has shown that of 55 per cent of local residents who wanted to be involved in a programme, only 2 per cent actually participated; and of 80 per cent of people who claimed to want to get involved in public services, only 25 per cent were actually prepared to give up their time when further questioned (Confederation of British Industry 2006). Successfully engaging with the community is often a crucial first step towards local

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empowerment; but it is one that requires careful attention to the barriers to and enablers of engagement. Barriers, such as time, financial costs, meeting on agency terms rather than in a community space and tokenism, are well known. Below we focus on a few key enablers: effective communication, participation opportunities and needs assessment.

Effective communication

Community engagement begins with people becoming better informed of issues that meet their own concerns and how they can become personally involved in addressing them. A lack of understanding can be addressed by having clearer and more accurately targeted information. Effective communication, however, is more than just informing community members about issues. Within a context of gaining people's participation in health-promotion programming, communication advice that aids the process of their engagement include

1. A single point of communication or person as a reference;
2. Clear information especially about the planning process of a programme;
3. Opportunities to consult with and provide feedback to the outside agency;
4. Opportunities to have an influence on the programme, for example, to be involved in the decision-making processes regarding policy change;
5. Systems that ensure that all stakeholders are accountable to a constituency (Confederation of British Industry 2006).

A common problem facing health promotion (and other social) programming, however, is the assumption that knowledge in itself is sufficient to change practice. Instead there is substantial evidence of a gap between what people know and what they do. Recent work in Viet Nam, for example, found that the knowledge of school pupils about the proper use of latrines (98%), safe water supplies (98%) and the prevention of worm infection (95%) was very high (Trinh et al. 1999). However, a study of worm infection in adults and children found rates for round-worm, thread-worm and hook-worm to be 83%, 94% and 59% respectively (Needham et al. 1998). Worm infection rates are felt to be a reliable indicator of hygiene practice and sanitary conditions.

This gap between knowledge and practice can be exacerbated by health promotion programmes that tend towards

- Reliance on top-down programming using largely didactic styles of communication;
- Communicators lacking the knowledge and skills to effectively use participatory methods and materials;
- Communication interventions lacking adequate research;
- Proper audience segmentation not being included in programme design, resulting in inappropriate message content and the exclusion of specific groups;
- Demand generated by the message content not being matched by supply, for example, the supply of condoms, latrines or hand-washing facilities (UNICEF 2001).

To bridge this 'know-do' gap, as it is now short-handed, requires that health promoters be very skilled communicators. They must know who else it may be important for community members to speak with about their concerns; and be able to facilitate effective intracommunity communication from the outset. Here it is useful to consider the theoretical arguments for communication put forward by the German social philosopher, Jurgen Habermas (1984). Habermas identifies two types of rationality that co-exist and frame every act of communication: a strategic or purposive rationality, in which we try to maximise self- or even collective material gain, that is, it is tied to the material world; and a communicative rationality, in which we try to maximise our understandings with one another. He argues that strategic rationality, by itself, is irrational, since in the absence of understanding what one's strategic behaviours mean to others, something only accomplished through communicative rationality, one cannot ensure that they will accomplish the desired results. Where this arises in groups, especially in their initial forming periods, is the balance between task (strategic rationality) and process (communicative rationality). But the more specific contribution Habermas makes to those trying to create empowering (or what Habermas would call 'emancipating') forms of community engagement is his four norms of 'ideal' communication:

1. What people speak is comprehensible; others understand its meaning because speakers have mastered logical argument and have expressive and interactive competence.

2. The propositional content (what people are proposing) is true; it is not logically or rationally false. This means that it can be defended by argument or evidence, a point we make later in our discussion of evaluating empowerment.
3. The propositional content is appropriate; it is justifiable on the basis of moral or ethical argument or theory. That is why this book opened with a brief discussion of equity, justice and ethics.
4. It is spoken with sincerity; the speaker more or less 'walks the talk'.

Remembering these basic norms can help to improve all forms of communication which, in turn, can help to build local trust, community participation and community confidence.

Participation opportunities

Ensuring opportunities for participation is also important to community engagement; it allows people to become collectively involved in activities which influence their lives and health. Participation has both instrumental and constitutive health effects. Instrumentally, it allows for greater programme effectiveness; constitutively, communities with greater rates of citizen participation also have comparatively better health, likely for the psychological sense of empowerment and control it creates (Labonté & Laverack 2001). Participation is a process that continuously changes and unfolds as individual actors and their varying group or organisational constituencies negotiate the terms of their relationships. In simplest terms, participation describes the attempts to bring different stakeholders together around problem-posing, problem-solving and decision-making. By stakeholder we mean:

1. someone with decision-making authority over the programme or policy;
2. someone significantly affected by the decision (this requires a judgement call over what 'significantly' means, but this should serve as a screen to limit the size of the eventual group);
3. someone who can make a key contribution to decision resolution (they may possess knowledge resources or material resources, and knowledge in this case is both the formal knowledge of researchers and academics and the informal knowledge of community members);
4. someone otherwise able to prevent or enable decision-making (such as a specific lobby or interest group).

It is also important to distinguish participation from other forms of engagement between governments, institutions and communities to

avoid the constant threat of tokenism (public involvement without authority). We can do this by defining three terms, often and incorrectly used synonymously: consult, involve and participate. Consultation is straightforward: We ask, but do not dialogue. Involve and participate are more complex. Their dictionary meanings are quite revealing. Involve means to 'wrap (a thing in another) wind spirally, entangle (person, thing, in difficulties, mystery, etc.); implicate (person in charge, in crime, etc.).make complicated in thought or form'. Participate means to 'have share, take part (in thing, with person); have something of . . . entitling to share . . . taking part.' The essential and significant difference between involvement and participation is the moment when others (individuals, groups) are invited to join in the problem-posing, problem-solving process. Involvement invites others after the problem has been named in quite specific ways; participation invites others to name problems in the specific ways most useful to the largest number. Involvement, like community-based programming, is often a useful and healthful action. The conundrum arises when the problem-naming (language, frames of reference) of the institution does not cohere with that of the community group and the latter attempts to respond on the terms set by the expert, becoming 'involved' in (wrapped up in, made more complicated by) these terms. This is sometimes the case when communities are asked to become 'involved' in health coalitions where the outcomes (e.g., CVD or cancer rates) have already been defined by the health agency, often accompanied by epidemiological data and arguments that use concepts and language foreign to citizens' day-to-day experiences. At the same time, an institutional demand for constant participation can be just as disempowering as involvement that masquerades as participation. It may represent a wasteful expenditure of citizen time, and excuse the failure of politicians to make difficult policy decisions. For public participation also carries opportunity costs (time, energy) and may not even represent *how* citizens wish to engage with institutions and professionals (Labonté 1997). Table 4.1 provides a simple *aide mémoire* for these different types of engagement.

One essential opportunity for people to participate is through meetings or forums to discuss concerns that are important to them. Such meetings typically begin with a brief introduction to the purpose followed by an introduction of the participants. The meeting is a facilitated group discussion to focus on a particular local concern such as public transport, unemployment and sub-standard housing. The meeting can be supported by audio-visual materials such as a poster or a

Table 4.1 Fundamental characteristics of participation, involvement and consultation

Participation:
- Negotiated, formalised relationships
- Open frame of 'problem-naming'
- Shared decision-making authority
- Full stakeholder identification
- Resources for stakeholder participation ('levelling the playing field')
- Stakeholder accountability to a larger constituency (the group they represent)

Involvement:
- Citizens treated as individuals rather than as organised constituencies
- Terms of engagement are ultimately in control of the agency sponsor
- Structure is advisory; it may have some, but very limited, decision-making autonomy
- Tendency to non-formalised agreements in which agency sponsor retains more invisible power

Consultation:
- Information from citizens sought on specific plans or projects
- Little or no structures for ongoing engagement between agency sponsors and its publics

Source: (Labonté 1997).

video to generate discussion, and can also be used to plan for actions, identify resources, identify potential partners and for people to openly express their views.

Susan George, an activist scholar associated with many local and international organisations, considers meetings the lifeblood of citizen and community empowerment. Many of us take for granted meetings and so use them less effectively and efficiently than we might. Over years of experience, George distils the important essence of such meetings to seven 'commandments' (George 2004), which we have embellished with some of our own insights:

1. Create a single page handout with a clearly written analysis, goals, strategies, accomplishments so far. Earlier meetings may be needed to develop this. The handout will need to be revisited from time to time, but amounts to a 'mission statement' for the group.
2. Welcome everyone at the start, asking for newcomers to identify themselves. Others at the meeting should be prepared to talk to newcomers at breaks or afterwards, to elicit their input in a more personalised way and to encourage them to return.

3. Set up a table where other information around the goals of the group is available. Someone should staff the table. This is where people can sign up to participate again in future meetings or activities.
4. Set up another table where other literature on related issues or community struggles can be placed. This allows people attending to make links between their concerns and those of other groups.
5. Make sure to plan, or announce an already planned, activity. There is a cliché: Communities thrive in action but die in committee. Meetings may be the lifeblood of empowerment, but empowerment is for a purpose and that purpose is fulfilled in actions besides simply meetings.
6. Ask for resources, financial or human (volunteer time). This is the test of relevance of the issues to people in communities. If it is sufficiently important, community members, even in the poorest of circumstances, will often be willing and able to give money, time or other in-kind support. Some progressive community funding agencies actually use a requirement of in-kind contribution as a way of ensuring that the activities they support have a reasonably broad base of community 'buy-in'.
7. Do all of this at the start of the meeting, not at the end when the noisy break-up begins and everyone is more interested in getting ready to leave than committing to new activities.

Needs assessment

Needs assessment provides another specific opportunity for community engagement. The question of who identifies the concerns to be addressed and how this will be taken forward is basic to empowerment. For practitioners, a key step is the identification of, support for and commitment to those concerns 'close to the heart' of communities. If practitioners are not willing to address the local concerns of communities the programmes they then help to implement are much less likely to succeed.

In practice, a compromise often has to be met between what the local concerns are and what the implementing agency wants to achieve. Health promotion is most often delivered through top-down programmes controlled by government agencies or government-funded NGOs. It is government policy (and resources) that sets the health promotion agenda, and the difficulty begins when this does not meet local concerns. Health promotion practitioners are employed to design and deliver programmes that promote health within the parameters set by government policy. So even when those in the 'top' structures agree with those at the local level

about the main concerns, the way in which the agenda is determined can still result in these issues not being addressed.

However, there are many practitioners who remain passionate about using empowering approaches even within the context of bureaucratic, top-down styles of health-promotion programming. These practitioners are adept at merging the boundary between local concerns and government agendas and have become imaginative at how to accommodate empowering approaches within top-down programmes – though, as Chapter 1 cautioned, their abilities to do so rest partly on the understanding and support they receive from their employing agency.

Engaging people to address local concerns can be facilitated by the practitioner through building partnerships and alliances with community members. The purpose is to facilitate the sharing of his/her power in a way that involves the provision of both services and resources, at the request of the community. Box 4.1 provides an example of how one local council engaged with communities to improve the delivery of public services.

Box 4.1 Improving the delivery of local services

Slough Borough Council in the UK set up a citizen's jury to decide how to improve their 'street-scene' services in response to concerns primarily from local residents. This included road maintenance and street cleaning. This was a new initiative to create a partnership between the Council and local residents and other stakeholders. A new delivery strategy was devised to bring refuse collection and disposal, recycling, street cleaning, grounds and highways maintenance into a single partnership. At that time these contracts were split between different contractors. The Slough Borough council was given a mandate to increase Council Tax to improve the service, so long as the benefits could be guaranteed.

A consultative board met every six months to help set service priorities, solve delivery problems and take forward campaigning and educational work. As a consequence local services improved rapidly and Slough is now one of the cleanest towns in the South of England. The 'Keep Slough green and tidy' campaign motivates the public to be actively engaged in the effort to increase recycling and decrease litter. The partnership has given local residents more of a 'voice' and has included them in the decision-making process to improve the environment in Slough.

(Confederation of British Industry 2006)

Building local partnerships

In a health promotion programme, one practitioner role is to provide leadership, enthusiasm and the resources necessary to move participation forward. However, this role expectation can soon change to one of more 'equal' partnership between the practitioner and the community. Partnerships demonstrate the ability of the community to develop relationships with outside agents such as local authorities based on the recognition of mutual interests and respect. The partnership may involve an exchange of services, the pursuit of a joint venture based on a shared goal or an initiative to take action to the benefit of all parties.

Local empowerment is about the redistribution of power (control of resources and decisions) often through devolution. Central bodies devolve, and support, local authorities who in turn devolve responsibility to, and support, other organisations and local people. We cautioned earlier that devolution without access to and authority over necessary resources is a form of 'community-blaming' rather than empowerment, and a strategy often used by conservative governments rolling back public entitlements to health, education or welfare benefits. As well, without strengthening community management capacities and ensuring that devolved services and programmes are not captured by local elites, decentralisation can actually work against the aim of improving health equity (Collins & Green 1994).

But even when devolution includes both resources and authority, many practitioners find it difficult to relinquish the control that they have over the design and implementation of a programme. Accepting the expertise offered by local people and sharing professional expertise so that the members can build their own empowering capacities can be difficult for some outside agents (a term we use to describe both individual practitioners and the government agency or NGO for which they work). Partnerships offer a framework in which the relationship between the practitioner and their clients can become more equal. Box 4.2 provides an example of engaging a community to take responsibility on some of the tough questions in regard to a local road maintenance project.

Health promotion practitioners have an important role in providing information, resources and technical assistance, but this role must support the concerns that have been identified by the community as being relevant and important to them. The provision of resources and technical support often provides the basis for partnerships to develop between the outside agent and the community.

Box 4.2 Improving local involvement in road maintenance

A private company was asked by the Oxfordshire County Council to develop a solution to increase the life of a major road in Oxford, UK including junctions, access and traffic calming. The work was planned to interfere as little as possible with local businesses and residents, by avoiding busy seasons and working when premises were closed. Road-user groups, local businesses and the police were involved from the design phase through regular public meetings. Residents were asked to choose from a series of options for the difficult decisions, such as when to work at busy junctions. The work itself was broken down into sections covering 200m of road and residents were told dates in advance and businesses were allowed to continue deliveries. The road maintenance was planned around the convenience of local residents and businesses who were also involved in making decisions on an ongoing basis. This type of an arrangement can become formalised as a 'neighbourhood charter' or a two-way partnership between communities and a service provider such as a construction contractor.

Maintenance of this sort does not usually involve such intensive and continuous public consultation, but it helped to ensure that the work started and finished on time by helping to identify problems in advance, and resulted in a higher level of local participation and client satisfaction. Other projects have employed a watchman-in-chief who engages with business, service users, parish councils, the Highways Agency and local representatives. Other watchmen identify issues across the area and provide feedback to the watchman-in-chief. The watch-keeper role provides a non-bureaucratic, informal method through which the outside agency can keep in touch with a range of stakeholders when appropriate, enabling a feedback and communication. The information provided is realistic and accurate and always allows local residents to provide their opinions and, if necessary, to be involved with the decision-making processes (Confederation of British Industry 2006).

Building community capacity

Sometimes communities know what they want but do not know how to achieve it. In other instances, communities may not know what they

want; express concerns more influenced by local media than critical reflection; or are constrained in identifying their concerns by internal conflict. The practitioner has an important role to play, especially at the early stages of a programme when community capacity has yet to be strengthened or developed, to support communities in identifying and/or addressing their concerns. This is often a temporary role and over the longer term the practitioner will be working towards reducing her initial leadership in the programme.

The programme design should clearly define how it will build the capacity of the community from planning, through implementation and management, to evaluation. Without this focus, the community can become dependent on the outside agent to provide support during the lifecycle of the programme without themselves building the necessary capacities.

Addressing community capacity is an important issue that is often overlooked in programming. Capacity building includes two key areas:

1. Firstly, the capacity of the community is strengthened so that members can better resolve their own concerns. This involves the development of specific skills and competencies which contribute to their overall capacity, and which are captured in the empowerment domains described in Chapter 2. These skills may be used later in a variety of circumstances; for example, the organisational skills that are developed to address a local concern such as flooding may be used again to address the siting of child-care facilities. Building community capacity therefore has a generic characteristic and is not limited to one issue only.
2. Secondly, the capacity of the community to take more control of the programme is enhanced. This often involves skills development based on programme management such as financial control, report writing and evaluation. These are skills that the community can use when it is involved in managing the programme.

The key practitioner point here is to provide the appropriate level of support at the request of the community. This means that the outside agent should not commit all the resources at the programme planning stage as new resource inputs will be identified as the strategic plan of the community is implemented. To meet this demand the outside agent should be flexible in the type and timing of resources that he is prepared to provide to support the community. In a programme, context resources are often designated to a specific budget category, for example,

travel costs, training and equipment. However, the resources requested by the community may not fit neatly into one of these categories. There are activities that may be difficult to justify as being strictly health promotion but that nonetheless build the social dimension of communities through a sense of belonging, connectedness and personal relationships. Examples of these types of activities include

- Organising a community event such as a sports or arts festival;
- Providing food and drink to encourage people in the community to meet;
- Providing transport to allow people to travel and take part in an event;
- Arranging child-care facilities to allow mothers to meet;
- Providing a 'petty cash' account to cover incidentals such as refreshments at meetings, gift vouchers and refunding individual travel costs.

In these instances, the practitioner's role is one of lobbying the funding body (which may even be her own employing organisation) to amend its budgetary or accountability requirements to be more conducive to programmes working from a community empowerment/capacity-building approach.

Influencing health policy

Having a policy in place does not guarantee that it will be followed, or that a community's health conditions will improve. But failing to have a policy in place that incorporates community health concerns and solutions will guarantee little or no change. Influencing public health policy remains fundamental to empowering health promotion work.

The public health policy process, however, is complex because it is difficult to sometimes define the causal links between a policy intervention and an improvement in health. There are powerful interests at stake such as the tobacco industry, pharmaceutical industry and the medical professions. There are shifting ideas about how best to deliver public health's ever-changing demands, and challenges posed by demographic changes and emergent health concerns such as obesity, SARS, multiple/extreme drug resistant infections (such as TB) and the persisting threat of a global influenza pandemic. The causes of many public health problems are due to poor nutrition, poverty, smoking and the environment; and there can be large differences in policy-relevant health

concerns between different social and ethnic groups, often within the same community. Developing policy solutions therefore involves the use of a range of intersectoral strategies (Gauld 2006), and a sensitivity to its intrinsic political nature. (Yeatman 1998). The people who control the political process (governments and governmental stakeholders at the national, municipal, regional and local levels) may or may not involve those who are influenced by the policy outcome in its development. The policy process can therefore be used as a 'power tool' to further exert control-over people resources and decision-making, or to shape policies in the interests of elite social groups with greater access to, and influence over, the political decision-making process.

People influenced by the policy, however, may not necessarily agree with it and may want to change its formulation or stop its delivery. Communities can influence the policy process by persuading or forcing those who control its development to change its design or delivery. Public participation in policy change can take the form of 'direct democracy' such as a referendum that can be prospective and government initiated, or more rarely, reactive and citizen initiated. This is large-scale voting on specific questions most commonly regarding constitutional issues about how people should live together and be governed, such as compulsory military service and changes in legislation (Parkinson 2006). Evidence suggests that people are reluctant to take direct forms of participation. For example, in New Zealand a study showed that of the 89 per cent of respondents to a petition only 19 per cent attended a demonstration, 17 per cent joined a boycott, 4 per cent joined in a strike and only 1 per cent were willing to occupy a building (Perry & Webster 1999) to try and influence a policy issue. There is also a pattern to poor public participation that includes young people, members of ethnic and other minorities and those with the lowest level of education and income who are the least likely to be involved; although some of these groups may be opting to use other forms of participation such as the Internet forums (Hayward 2006). Ironically, it is these groups who are most likely to be affected by policy decisions because they have less of an economic or social 'buffer' to protect them from changes in, for example, employment, housing or welfare policies.

Influencing policy is an important form of participation that can be a direct expression of local empowerment. But more often, public participation takes a passive form such as voting, signing a petition or writing a letter to someone in the political system. Marginalised groups often lack the resources or level of organisation necessary to have a strong 'voice' through, for example, a boycott or legal action. It is therefore essential that they are assisted to become more active in influencing the

policy process at its different stages of development. This is possible because, far from being predictable, the policy process is reliant on the ability of the different stakeholders in civil society and in government to negotiate a compromise.

Models of the policy process

Several useful frameworks have been developed to conceptualise how people can act to change the 'prevailing paradigm' of policy development. In particular Lindquist (2001) offers an interesting view, provided in Table 4.2, of a framework to influence policy.

In addition, to Lindquist's framework a number of models have been developed that can guide the analysis of influence in the policy process. It should be noted that these models primarily reflect processes in the developed world and assume a democratic political system. The models provide in-depth conceptualisations about how this process works within two broad paradigms: rationalist and political (Neilson 2001). The rationalist paradigm includes linear, incrementalist and interactive models as representations of the policy process. It originates from classical economic theory which presumes that actors have full information and are then able to establish priorities to achieve a desired and largely uncontested goal. It is driven by the production and consideration of different forms of evidence such as public health research, and the input

Table 4.2 A framework to influence policy

Types of Policy Influence:
1. Expanding Policy Capacities • Improving the knowledge/data of certain actors • Supporting recipients to develop innovative ideas • Improving capabilities to communicate idea • Developing new talent for research and analysis
2. Broadening Policy Horizons • Providing opportunities for networking/learning within the jurisdiction or with colleagues elsewhere • Introducing new concepts to frame debates, putting ideas on the agenda, or stimulating public debate • Educating researchers and others who take up new positions with broader understanding of issues • Stimulating quiet dialogue among decision-makers
3. Affecting Policy Regimes • Modification of existing programmes or policies • Fundamental redesign of programmes or policies

from experts and academics is a valued part of the process. Tim Tenbensel and Peter Davis (in press) provide as an example of the rationalist model, government decisions on the purchase of pharmaceutical products for health service delivery. In developed countries these are rational decisions made on the basis of a 'cost-benefit' analysis and available information. If, however, insufficient or incorrect information is available or the policy goal is highly contested, the rationalist paradigm offers limited guidance to how policy can be planned or influenced.

The political paradigm generates policy models adapted from political economy theory and derived from comparative politics and international relations. These theories stress the important of agenda setting, policy networks, policy narratives and the policy transfer in shaping final decisions (Neilson 2001). Policy decisions, in turn, are made on the basis of bargaining and negotiation between the many different stakeholders who employ a range of approaches to have an influence on each stage of the policy process, discussed below. From the vantage of health policymakers, the most effective approach to policy combines elements from both the rational and political paradigms. For example, the introduction of policy to ban smoking in public places was initially based on strong epidemiological evidence regarding second hand smoke. However, the best strategy to reduce death and illness from second hand smoke would be a total ban on smoking, including in homes. Obviously such a policy would be very difficult to police as well as would create opposition from civil libertarian groups. The policy decision was therefore a compromise based on the available evidence and the opposing interests of different stakeholders to reach an achievable goal rather than an optimal goal (Tenbensel & Davis in press). From the vantage of those aiming to influence the policymaking process, similar compromises may be necessary, with each stage in the process, offering opportunity for input or advocacy.

The steps to influencing health policy

At a practice level, the policy process can be defined as a framework that has six steps: (1) Identify issues, (2) Policy analysis, (3) Undertake consultation, (4) Move towards decisions, (5) Implementation and (6) Evaluation (Edwards et al. 2001). All these steps are subject to internal politics as well as to the politics of the state and the apparatus of administration and management that it employs. What follows is an explanation of how the policy development cycle can be influenced by people in civil society, community groups and advocacy groups often assisted by health promotion practitioners.

Identify issues

Initially the problem has to be defined and articulated before it can be properly considered and a decision be made as to whether to include it on the policy agenda. Government policy agendas are often crowded and so issues that are to be selected are in competition with one another. It is useful if those people proposing the problem can demonstrate that it is an undesirable situation and one that is getting worse. In particular, they need to show that some public harm will result unless action is taken and that this harm is able to be expressed in terms of social and economic aggregates or health outcomes. For example, policy actions on obesity or smoking are more likely to be considered when the longer-term social and economic effects, such as increased health expenditure and loss in worker productivity, can be shown. Similarly, the threat of litigation for economic costs, a strategy frequently used in the USA, has been used effectively to change the production, marketing and retail practices of tobacco companies (smoking-related damages) and food oligopolies involved in the processed/fast food industry (obesity-related damages). Finally, as we noted in Chapter 3, the problem has a greater chance of being recognised as a policy issue if there is a simple solution to resolve the situation and if government intervention is justified (Tenbensel & Davis in press); for example, to promote an increase in physical activity and smoking cessation in the population, or to provide access to essential medicines.

The responsibility to place a policy issue on the government agenda usually rests with the appropriate minister. The minister has to ensure that there is a broad enough understanding and acceptance of the issue so that it has a good chance of moving forward in the policy cycle. This provides an opportunity to influence the policy cycle through indirect actions such as lobbying the responsible minister, for example, by sending a letter, email or text message, signing a petition or meeting with the minister and other politicians. It is also an opportunity to influence the policy cycle through non-violent direct actions, for example, by taking part in peaceful demonstrations and public protests. The media can also play a significant role and people can engage in a publicity campaign to try and influence the decisions made by the minister in selecting the policy agenda, for example, an issue that is obviously widely unpopular with the public may have less chance of being selected.

But to what extent can public action have an effect on defining the policy concerns of government? Government action on policy can be seen as a democratic enterprise that, in theory, reflects the needs or wants of a

significant proportion of the public. The public can express what they want through indirect and direct actions discussed earlier, and can challenge the government arguments put forward for defining a particular policy 'problem'. The basis of these counter-arguments may be supported by science and research which in turn can be contested on the value basis of the problem definition. For example, activists in the USA have successfully reframed the obesity problem from one of health to one of 'the right to be fat' based on the role of diversity and acceptance in society (Tenbensel & Davis in press). Inevitably, the success of one group's argument over another group's counter argument may be based more on access to the resources that enable them to put forward a more aggressive and convincing campaign than the positioning of the issue in relation to the value of matters of public health and safety or individual rights. An important element of such a campaign is the media as it has the potential to widely influence public opinion. An advocacy truism is that having media coverage of an issue does not guarantee it will receive political attention; but a lack of media coverage does not guarantee it political attention. If governments are shown to be unresponsive to public demands for action this can create the opportunity for others who do support the issue to step in and to carry the issue forward.

Policy analysis

Policy analysis commonly involves at least three elements: collecting the relevant data; clarifying the objectives and resolving the key questions that have been raised, and identifying the options and proposals that will form basis of the policy reform. An important factor is the level of investment made at this stage to ensure a thorough analysis of the issues and to provide sufficient clarity so that decisions can be quickly made to devise solutions to problems. But even when a policy solution exists it may have to wait for a correct political climate such as in the case of passive smoking. The scientific evidence against the causal link of passive smoking and ill health had existed for some time before it became a policy priority that was motivated from a position of moral and personal rights. This is when the 'window of opportunity' presented itself to act to introduce policy with the support of the public (Berridge 1999).

Public health advocates, researchers and academics can play an important role in helping to identify and provide the evidence necessary to resolve any issues arising during the analysis. This can be an opportunity to use lobbying tactics to try and influence staff working in government 'policy shops' who are often looking for evidence to support one or more

Box 4.3 The role of media: Advocacy that changes the frame

There are several truisms about health advocacy:

1. Without advocacy we cannot improve health. This attests to the importance of social determinants in influencing health, and the need to use policy levers to affect these determinants.
2. Health advocacy often conflicts with market liberalism. This speaks to the fact that these policies (regulatory and redistributive) often challenge elite interests vested in 'free market' ideology.
3. Advocacy requires taking a position where there is controversy. This simply notes that, when there are no competing interests in a policy area, there is no need for advocacy.
4. Advocacy involves risk-taking. This reminds us of Virchow's advocacy experience recounted in Chapter 1.

One key strategy frequently used by health advocates has been dubbed 'media advocacy', using mass media to shift the frame in which policy issues are defined. Media advocacy differs from social marketing, which attempts to persuade changes in personal behaviours. Media advocacy targets policies, policymakers and the ways in which issues come to be regarded as newsworthy or important. As Lawrence Wallack, one of media advocacy's founding scholars, comments, [T]he media agenda determines the public agenda: what's on people's minds reflects what is in the media (Wallack, 2005). Most mass media continue to frame health issues as medical cure or treatment, difficulties in getting access to treatment (waiting lists, uninsured new treatments) or the need to change unhealthy behaviours (most recently, fitness, nutrition and obesity). Since medical and behavioural health issues dominate news coverage (Gasher et al. 2007), this is what gets most attention by policymakers. Media advocacy attempts to challenge this dominance by changing the frame. This is easier to do with individual-level stories or issues than with broader social determinants. Media advocates, for example, successfully shifted tobacco control policy away from targeting smokers to targeting the tobacco and advertising industries. Similar media-targeted campaigns, increasingly with global reach, have been used to focus attention on access to antiretroviral drugs in developing countries. But social determinants 'stories' are inevitably policy analyses

(Continued)

Box 4.3 *(Continued)*

pieces, which require more depth and detail, and are less frequently covered by mass media than so-called 'hard news' stories (Gasher et al. 2007). A perennial challenge to media advocates concerned with the social determinants of health is how to capture media attention and reframe the health debate. Some examples culled from our own experiences: Staging a public event where an actual over-sized pie was sliced according to quintiles to show the increasing inequalities in wealth distribution over time; countering stories of surgery wait-times with tales of waiting lists for subsidised housing for low-income families; organising large-scale demonstrations or marches that drew attention to deepening poverty rates and the need for welfare reforms. While media coverage of these more profound health determinants, and the policy changes needed to address them, remains a distant third to medicine and lifestyles, it appears to be growing. With its slow rise comes another challenge: framing the policy debate in ways that do not stigmatise the poor or rob them of dignity or agency. The increasing role of the Internet in political campaigning, and the opportunities it presents for multiple creative ways of framing and reframing issues, is rapidly changing the entire frontier for media advocacy and policy engagement.

of the range of policy options they are exploring. But as the policy analysis is mostly undertaken internally and in confidence, the level of public influence may be difficult.

Undertake consultation

Consultation can be formal or informal and may occur at any stage of the policy process. Consultation is often facilitated by the issue of a discussion paper which outlines the policy intentions and allows feedback from individuals, groups and civil society. People may be formally asked for a response to the discussion paper or it may be placed in the public arena to stimulate an open debate on the issues. The purpose is that the consultation stage will lead to a refinement of the policy and a wider public acceptance of its intentions.

It is at this stage that there is the greatest opportunity for 'legitimate' public engagement in the policy process. A number of indirect actions can be taken to influence the policy process such as local meetings to discuss the draft policy paper, signing a petition for or against the policy paper,

sending an email, fax, text or letter to a minister or local government officer or delivering promotional material to other people. A number of direct actions can also be taken to influence the policy process such as participating in public protests or by supporting a publicity campaign. The purpose of these actions is to ensure that the people involved in making the decisions are aware of their opinions and support for or against the policy, especially important when policy choices are strongly contested. Since health promoters are often in a position to help draft policy, and to convene consultations, they must also be critically reflective on when such consultation (or a fuller form of participation, as we distinguished earlier in this chapter) is appropriate. While the move to community participation by many governments is a potentially healthy step towards a more civil society, it is not always clear whose interests are being served most. Participation may have become a ritual, devoid of critical reflection on how it might be more or less empowering for the communities affected. In the end, bureaucrats become more empowered because they can say, 'I've consulted with the community, and therefore my conclusions have more politically correct weight.' If these conclusions truly do benefit local community groups, this is not necessarily a bad outcome. But that may not always be the case; and unless health promoters are clear on the reasons why they are engaging with communities on policy issues, they risk draining the energies of community groups in meetings or discussions of more importance to their institution than to the community.

Move towards decisions

Following analysis, debate and policy refinement the necessary decisions can begin to emerge. Firstly, the decision will be made by the appropriate person and then the policy proposal will be put forward for approval by the government or the necessary body with authority. In spite of the earlier analysis and consultation the final decision will have to consider issues of economy, efficiency and equity. A compromise may have to be reached, for example, one in which the policy is phased-in over a period of time to allow sufficient funds to be made available. Alternatively, the policy reforms may be introduced as a package alongside other measures, assistance and benefits. The purpose is to publicly introduce the policy reform with a minimum of opposition and criticism.

At this stage of the policy process if people are opposed to the decisions, they can continue to use a range of direct and indirect actions: the threat of collectively withdrawing their votes for those making the decision, engaging in an aggressive publicity campaign against the policy decision or instigating legal action against those making the policy decision. The

purpose of these actions is to try and force those making the decision to agree upon a compromise in favour of the opinions of those against it.

Implementation

Once the decisions have been made and approved, the policy enters a period of implementation towards the desired outcomes. If the policy reform is clearly defined, has general support and is well resourced then the implementation should be successful. However, the implementation of new policy invariably entails some modification to the existing policies (Burris 1997). Unless the implementation is delivered well and sensitively, it can result in problems and even failures.

Evidence from policy implementation has found a number of causes for a failure at the implementation stage including ambiguity in the policy itself, conflict with other policies, having low political priority or engendering conflict with significant stakeholders (Edwards et al. 2001). In particular, 'bad publicity' can have a detrimental affect on the implementation of the policy especially as decision makers often lose interest at this stage and insufficient resources are given to promote the reforms. On the other hand, the greatest likelihood of implementation success is when the policy is technically simple, necessitates only marginal changes in existing policy, is delivered by one agency, has clear objectives and a short duration (Walt 1994).

Policies can actually be reformulated at the implementation stage and this provides the opportunity to interfere with and possibly stall the process of implementation by opposing stakeholders. The best chance of success they have is if the effect of 'bad publicity' can be harnessed against the policy reform. To do this they may have to use radical actions such as staging protests with the intention of attracting publicity or creating an outrageous media stunt such as climbing a public building to deploy a banner advertising a message against the policy reform. Another tactic is by placing oneself in a position of 'manufactured vulnerability' to prevent implementation such as squatting in a building to be demolished or living in a tree to be cut down. Some people may decide to take violent and illegal forms of direct action such as 'hacktivism' by accessing a computer to obtain information or placing a virus to sabotage a database or by physically altering something to prevent implementation such as 'spiking' tress with metal pins or blocking vehicles by 'sit-ins' on roads.

Evaluation

The monitoring and evaluation of the policy can lead to incremental revisions if reforms are not being met, or met efficiently. For example, if

the purpose of the reform was to increase equity and participation in child support but this was shown not to have happened, the policy may be changed and reimplemented. The evaluation can be influenced by a broader political agenda which may also have changed since the original policy decision had been made. It may then be more difficult to justify a continuation of the policy if, for example, it now has a lower priority in the political agenda. Policy evaluation gives further hope to those who, if their actions and tactics to influence it have been unsuccessful, can use the revision process as a means to reintroduce changes to, or to stop, the reforms. Ultimately, the evaluation, influenced by the actions of others, can recommend that the policy reform be revised or cancelled, although evidence of this is rare. Unfortunately, the evaluation of policy is invariably never attempted except for small-scale programmes or initiatives. This could be because policy is 'owned' and implemented by more than one stakeholder and objectives may be too diverse or ambiguous to allow a clear evaluation (Tenbensel & Davis in press).

Evaluating local empowerment

Evaluation is important in health-promotion programmes, as well as in the policies that shape them. Evaluation in a health-promotion programme context has many purposes. These include providing inputs to ongoing activities, information for future programme design, evidence of effectiveness (have I met my targets?) and efficiency (the outputs in relation to the inputs), accountability to funders and participants, and the potential for sustainability over time. But evaluation that empowers also ensures that it addresses people's local concerns and provides the information that they need to make better-informed decisions that go beyond the programme's own goals. Evaluation that empowers, further emphasises the participation by people actively involved in the programme in the evaluation process. The evaluation itself ideally becomes an empowering experience by building skills and competencies of community members.

The key characteristics of an empowering evaluation

Certain commitments have been identified by Labonté and Robertson (1996) and Wadsworth & McGuiness (1992) as good ideals for an 'evaluation that empowers':

1. Respect for all parties as equal yet possessing different values, concerns and meanings, all of which are all equally important.

2. A determination to seek all parties' perceptions.
3. An opportunity for all to discuss and interpret the findings in order to reach a consensus on the best explanation.

The key characteristics for the evaluation of local empowerment also include considerations for the design and implementation of the approach:

Design

- Applies principles of rigour that are technically sound, theoretically underpinned and field-tested.
- Uses appropriate methods.
- Addresses programme effectiveness and efficiency.
- Addresses programme achievements and inputs.
- Addresses ethical concerns.

Implementation

- Clearly defines the roles and responsibilities of all stakeholders.
- Use participatory, self-evaluation approaches.
- Information provided can be interpreted by all stakeholders.

Outcomes

- Provides information that is accurate and feasible.
- Ensures that the stakeholders can use the information to make decisions and to take actions.
- Findings use a mix of interpretation, for example, textual and visual (Laverack 2007).

Measurable indicators of local empowerment

Apart from evaluation of specific health-promotion programme goals or objectives, on which much has been written that will not be recounted here, there is the matter of tracking change in empowerment itself. Empowerment is a complex concept. While empowerment approaches have an explicit purpose to bring about social and political change embodied in their sense of action and political activism (Laverack 2007), other approaches provide a focus on the individual (Zimmerman & Rappaport 1988), the organisation (Israel et al. 1994), the family (Haynes & Singh 1993) and the community (Wallerstein & Bernstein 1994). But of the different levels of empowerment it has been the psychological level and the use of predetermined outcome indicators

which have received the most attention in terms of measurement (Rissel et al. 1996; Zimmerman & Rappaport 1988; Labonté 1994b).

At a psychological level, people experience an immediate and personal form of empowerment, such as an increase in self-esteem or self-confidence (Labonté 1998). Though partially measured as self-esteem or self-efficacy, psychological empowerment is a construct which incorporates the person's perceptions and actions within their social context (Zimmerman 1990). Empowerment can therefore mean different things to different people as a personal experience and it is likely to be incremental and often relative to the interpersonal relationships of the person concerned as the subjective elements of empowerment.

Empowerment can also be viewed as both a process and an outcome. Outcome indicators cover the level of control gained over a range of social, political and economic factors. Empowerment has a long time frame, at least in terms of significant social and political change, for example, a change in government policy or legislation. Health promotion programmes typically have a shorter time frame and the measurement of outcome might not take into account processes such as capacity building and the development of new competencies and skills. It may not therefore be possible to measure empowerment outcomes during a programme period. However, by measuring empowerment as a process, it is possible to monitor the interaction between capacities, skills and resources during the timeframe of a programme.

The process of local empowerment can be measured by reference to the nine distinct 'domains' discussed in Chapter 2, that is, tracking how a health promotion programme (1) Improves participation, (2) Develops local leadership, (3) Builds empowering organisational structures, (4) Increases problem-assessment capacities, (5) Improves resource mobilisation, (6) Enhances the ability of the community to 'ask why' (critical awareness), (7) Strengthens links to other organisations and people, (8) Creates an equitable relationship with the outside agents and (9) Increases control over programme management. There are many potential ways in which local empowerment, and changes in the nine empowerment domains, might be evaluated. The approach outlined below is one that has been applied in different programme and cultural contexts. The approach is robust and reliable and the experiences of its application are discussed in detail elsewhere (Laverack 2003).

Measuring local empowerment

The approach uses a 'workshop' style setting. The workshop design should be flexible and needs to consider some basic elements such as

the homogeneity of the group, its dynamics, size and the time frame for the exercises. It typically takes one day to complete the baseline assessment. The participants of the workshop are representatives of a 'local community' that share the same interests and needs.

Setting the baseline

The community representatives firstly make an assessment of each domain. To do this they are provided with five statements for each 'empowerment domain', each written on a separate sheet of paper. The five statements for each domain have been published elsewhere (Laverack 2005, 2007) and are summarised in Table 4.3. The five statements represent a description of the various levels of empowerment related to that domain. Taking one domain at a time the participants are asked to select the statement which most closely describes the present situation in their community. The statements are not numbered or marked in any way and each is read out loud by the participants to encourage group discussion. The descriptions may be amended by the participants or a new description may be provided to describe the situation for a particular domain. In this way the participants make their own assessment for each domain by comparing their experiences and opinions.

Recording the reasons why

Recording the reasons why the assessment has been made for each 'domain' is important so that this information can be taken into account during subsequent assessments. It also provides some defensible or empirically observable criteria for the selection. This overcomes one of the weaknesses in the use of qualitative statements, that of reliability over time or across different participants making the assessment (Uphoff 1991). The justification needs to include verifiable examples of the actual experiences of the participants taken from their community to illustrate in more detail the reasoning behind the selection of the statement; recall that this is one of Habermas' norms for 'ideal' communication.

The visual representation of local empowerment

Finally, the measurement of local empowerment can be visually represented to provide a means by which to share the analysis and interpretation of the evaluation with all the stakeholders. Visual representation allows information to be compared over a specific time frame, between the different components within a programme and between programmes. Visual representations do not have to use text and are therefore useful in a cross-cultural context or when stakeholders are not

Table 4.3 Five representative statements for each empowerment domain

Domain	1	2	3	4	5
Community participation	Not all community members and groups are participating in community activities and meetings, such as women, youth, men.	Community members are attending meetings but not involved in discussion and helping.	Community members involved in discussions but not in decisions on planning and implementation. Limited to activities such as voluntary labour and financial donations.	Community members involved in decisions on planning and implementation. Mechanism exists to share information between members.	Participation in decision-making has been maintained. Community members involved in activities outside the community.
Problem assessment capacities	No problem assessment undertaken by the community.	Community lacks skills and awareness to carry out an assessment.	Community has skills. Problems and priorities identified by the community. Did not involve participation of all sectors of the community.	Community identified problems, solutions and actions. Assessment used to strengthen community planning.	Community continues to identify and is the owner of problems, solutions and actions.
Local leadership	Some community organisations without a leader.	Leaders exist for all community organisations. Some organisations not functioning under their leaders.	Community organisations functioning under leaders. Some Organisations do not have the support of leaders outside the community.	Leaders are taking initiative with support from their organisations. Leaders require skills training.	Leaders taking full initiative. Organisations in full support. Leaders work with outside groups to gain resources.
Organisational structures	Community has no	Organisations have been established	More than one organisation which are active.	Many organisations have established links	Organisations actively involved in and outside

	organisational structures such as committees.	by the community but are not active.	Organisations have mechanism to allow its members to provide meaningful participation.	with each other within the community.	the community. Community committed to its own and to other organisations.
Resource mobilisation	Resources are not being mobilised by the community.	Only rich and influential people mobilise resources raised by community. Community members are made to give resources.	Community has increasingly supplied resources, but no collective decision about distribution. Resources raised have had limited benefits.	Resources raised are also used for activities outside the community. Discussion by community on distribution but not fairly distributed.	Considerable resources raised and community decides on distribution. Resources fairly distributed.
Links to others	None.	Community has informal links with other organisations and people. Does not have a well-defined purpose.	Community has agreed links but not involved in community activities and development.	Links inter dependant, defined and involved in community development. Based on mutual respect.	Links generating resources, finances and recruiting new members. Decisions resulting in improvements for the community.
Ability to 'ask why'	No group discussions held to ask why about community issues.	Small group discussions are being held to ask 'why' about community issues and to challenge received wisdom.	Groups held to listen about community issues. These have the ability to reflect on assumptions underlying their ideas and actions. Are able to challenge received wisdom.	Dialogue between community groups to identify solutions, self- test and analyse. Some experience of testing solutions.	Community groups have ability to self-analyse and improve its efforts overtime. This is leading towards collective change.

(Continued)

Table 4.3 (Continued)

Domain	1	2	3	4	5
Programme management	By agent.	By agent in discussion with community.	By community supervised by agent. Decision-making mechanisms mutually agreed. Roles and responsibility clearly defined. Community has not received skills training in programme management.	By community in planning, policy and evaluation with limited assistance from agent. Developing sense of community ownership.	Community self-manages independent of agent. Management is accountable.
Relationship with outside agent	Agents in control of policy, finances, resources and evaluation of the programme.	Agents in control but discuss with community. No decision-making by community. Agent acting on behalf of agency to produce outputs.	Agents and community make joint decisions. Role of agent mutually agreed.	Community makes decisions with support from agents. Agent facilitates change by training and support.	Agents facilitate change at request of community which makes the decisions. Agent acts on behalf of the community to build capacity.

Source: Laverack 1999.

literate (Laverack 2005). Graphing differences over time allows conclusions to be drawn about the effectiveness of building community empowerment in a programme context. The community members and the outside agent can provide a textual analysis to accompany the visual representation to explain why some domains are strong and others are not. The visual and textual analysis can be used to develop strategies to build community empowerment during a specific period such as between programme reporting cycles. The visual representation provides a 'snapshot' of the strengths and weaknesses of community empowerment as a whole.

Not surprisingly, several authors have used visual representations as a tool to compare changes that can influence the process of community empowerment. For example, John Roughan (1986), a community development practitioner, developed a wheel configuration and used rating scales to measure three areas – personal growth, material growth and social growth – for village development in the Solomon Islands. The rating scale had ten points that radiated outwards like the spokes of a wheel for each indicator of the three growth areas. Each scale was plotted following an evaluation by the village members to provide a visual representation of growth and development. The approach used a total of 18 complex, interrelated indicators such as equity and solidarity to evaluate village development. Rifkin et al. (1988) in Nepal and later Bjaras et al. (1991) in Sweden, were the first commentators on the use of the 'spider web' configuration for the visual representation of community participation. Their approach identifies five factors: leadership, needs evaluation, management, organisation and resource mobilisation and uses a similar simple rating scale. Marion Gibbon (1999), a community development practitioner, in her measurement of community capacity in Nepal utilised a set of eight factors and a set of indicators with a rank assigned from 1 (low) to 4 (high). The rankings were then plotted onto a spider web configuration similar to the approach used by Rifkin et al. (1988).

Evaluation information, however presented, is especially important to compare progress within a community and between communities in the same programme. It is a useful means to promote the free flow of information and allow all stakeholders to visualise, to better articulate and share their ideas on the building of community capacity towards local empowerment. Importantly, evaluation provides link between measurement and tangible community actions through participation and strategic planning (Laverack 2006).

As important as meeting these local challenges, and measuring progress towards community empowerment goals remains, our health and what determines it is increasingly embedded in global economic, political and social processes. Globalisation is no longer an abstract idea that health promoters, in their measured pursuit of local empowerment, can ignore.