Improving patient and community empowerment: the participatory action research/learning as an alternative approach.

Dr. Lai Fong Chiu  
University of Leeds, UK. Email: l.f.m.chiu@leeds.ac.uk

"If the living, experiencing being is an intimate participant in the activities of the world to which it belongs, then knowledge is a mode of participation, valuable in the degree in which it is effective. It cannot be the idle view of an uninterested spectator." [Dewey, J. (1916) Democracy and Education, p.338]

Introduction The goal of the Migrant Friendly and Cultural Competent Task Force is to improve the delivery of hospital services in Europe for migrants through the identification, development and evaluation of effective practice. The objectives of its Patient & Community Empowerment (PCE) working group are to identify existing knowledge and practice of patient and community empowerment, and to further develop this knowledge and practice. Formulating a set of guidance around PCE for healthcare organisations is the first step in working towards these objectives. In the course of reviewing the existing knowledge base, it was found that among other area of concerns i.e. communication, socio-cultural responsiveness, and monitoring of migrant health and health care, empowerment (Biscoff, 2003), is the most nebulous and conceptually least developed. This paper identifies some of the fundamental problems of relying on conventional research to enlighten our understanding of empowerment and inform our practice, and suggests that Participatory Action Research and Learning (PAR/L) should be appropriated as an alternative approach for the purpose of improving empowerment practice in healthcare organisations.

Empowerment in context The argument for the need to empower migrant patients and their communities is well rehearsed in the Amsterdam Declaration (2004) and is not to be repeated here. While much of the debate around empowerment centres on its definition(s) (Rappaport, 1984; Wallerstein, 1992), it is commonly accepted that its core values are human rights, equity, and social justice; and that strategies for empowerment are multi-levelled i.e. individual, organisational, and communities (Zimmerman 1995; Israel et al, 1994, Chiu, 2003). Implementation should attend to the diversity of contexts and settings (Anderson, 1996). It is then disconcerting to find that published health interventions that profess to empower patients or communities have tended to remain on the level of cognitive and behavioural changes with health outcomes as the major focus (Biscoff, 2003 pp78-88). Much of the understanding of empowerment and its relationship to changes in fundamental structures and relations of power, capacity building, fighting discrimination, and above all, engagement and participation, appear to have been ignored.

Empowerment and its knowledge production The consistent failure to connect the theories of empowerment and its practice can be traced back to the dominance of the bio-medical paradigm in health research and the erroneous assumption that positivistic methods (randomised controlled trials) are gold-standard for evaluating the effectiveness of any intervention. The pursuit of absolute truth in the bio-medical sciences has influenced funding themes and conceptual categories (Beeker, Guenther-Grey & Ray, 1998), intervention design, and publications. Knowledge produced under this orthodoxy is often presented in terms of probabilistic truth, and interventions devised within it tend to focus on imparting information and education. Important as these might be, they can
only be part of the strategy for empowerment. Although some interventions do acknowledge the participatory process, what constitutes participatory activity in the process is unclear and reports on these activities often lack reflectivity and reflexivity. In addition, the mechanisms of empowerment are seldom delineated. Therefore, models of good practice gleaned from this literature are insufficient to inform practitioners who wish to adopt empowering practice or to policy makers who are keen to evaluate what works.

**Epistemological problems identified** Based on the practice of the Community Health Educator model, a community empowerment model in health promotion developed iteratively in the U.K. over the past 15 years through five consecutive participatory action research projects (Chiu, in press), it is suggested that the present conceptual and practical difficulties of implementing patient and community empowerment are, by and large, an epistemological problem brought about by the afore-mentioned orthodox mode of knowledge production. If we accept that empowerment is a process by which patient and community are enabled to gain control over their health, then the participatory process is pivotal. This concept of empowerment recognises the existence of agency in people and their own capacity and determination for change. Thus knowledge produced under a set of conditions in which migratory experience and ethnicity are viewed as independent variables of experimentation on which health outcomes depend, and the researcher as an impassionate ‘observer’ and ‘knower’ and patients or members of communities as passive and ‘unknowing' subjects, violates the core principles of empowerment. The use of controlled trial methods in complex health intervention often inhibits feedback and involvement of patients and communities. It is at best likely to be ineffective in terms of providing an adequate explanation of what works and, at worst, risks serious ethical consequences. Most important of all, such an approach blinds us to the importance of developing participatory praxis and local knowledge that are required for implementing and sustaining empowering practice (Chiu, in press).

**Achieving empowerment through Participatory Action Research/Learning** Developing participatory praxis is important as it allows the structure of power to be revealed and facilitates the exercise of power by the marginalised. From this perspective, empowering patients and communities requires not only that we know what empowerment is, but also how it can be achieved. PAR/L is grounded on the pragmatist philosophy (Pearce, 1905; James 1907, Dewey, 1916 & Rorty, 1979 ) in which experience, practice and action form the basis of all knowledge and within which, the primary purpose of knowledge is to serve practice (Reason & Bradbury, 2001). Based on his extended epistemological framework, Heron (1996) distinguishes between experiential, representational and propositional (theoretical) and practical knowledge. From this perspective, we can begin to see how empowerment knowledge and practice can be related. Furthermore, the participatory worldview of PAR/L is closely aligned with the twin principles of participation and empowerment of health promotion. The orientation towards action and collective action for social transformation is compatible with the practical knowledge of empowerment needed by MFCC healthcare organisations. Adopting the PAR/L approach has the following advantages:

**Theoretical advantages:** Because PAR/L is developed from the human and social sciences, the theoretical resources that it provides for reflection on experiences and experimentations are rich and diverse (Chiu, 2006). If achieving patient and community empowerment in the MFCC healthcare context requires us to focus on cultural beliefs and social practices that are linked theoretically to individual, interpersonal, organisational and community transformation, understanding of the practice of
empowerment cannot be based on the traditions and modes of thought of a single discipline. PAR/L is open to a range of theories i.e. phenomenological, psychological, anthropological, and sociological, which can be mobilised to understand the complexity of empowerment, and sensitize us to opportunities for and barriers to it. Thus it can broaden the array of strategies available to achieve transformation. These can include:

- critical awareness of the influence of cultural practices of a specific community on health service access, treatment and care of the individual migrants;
- improved leadership, problem-solving and cultural competence at the individual, organisational and community levels;
- mobilisation of community resources to participate in policy formulation and intervention activities as well as combating discrimination;

Empirical advantages: PAR/L provides an opportunity to go beyond the goal of achieving cognitive and behavioural change in individuals, to the goal of systemic and structural change. Barriers to transformation can be conceived as practical problems that manifest themselves on different levels of social practice. Because of the complexity of the problem identified, its solution requires a multi-pronged approach and methods. PAR/L allows the use of a range of methods and is unrestricted by the notion of incommensurability espoused by paradigmatic orthodoxy; so long these methods serve to transform practice and bringing about empowerment, participation and social justice. Therefore, researchers or managers who adopt PAR/L will find greater latitude and creativity in terms of methods use. For example, unconventional techniques such as mapping, drama, art, dialogue, and storytelling, are used alongside more conventional techniques such as mathematical modelling, field trials, surveys, interviews, focus groups, ethno-biography, and visual and observational methods etc. Some of these methods are particularly useful for working with people who may have low levels of literacy, poor health literacy and who may not be fluent in the language of the host community.

Ethical advantages: Healthcare organisations that aspire to empower can define their roles vis-à-vis local issues and their capacity for change. PAR/L projects are built around the process of identification of problems, solution generation and solution implementation and evaluation (Chiu, 2004). The whole process is then critically reflected upon to draw lessons that might improve practice. These iterative cycles of action and reflection on the individual, interpersonal and collective levels form the very substance of knowledge creation (Chiu, 2006). Under these circumstances, knowledge production is not an individual activity but a collective endeavour supported by collective experience of the problem. Through attention to the often unequal power dynamic and relationships between participants i.e. researchers, professionals, patients and communities, a levelling effect of power is more likely using the PAR/L approach.

What works? The generative effect of learning in action Learning that occurs in the PAR paradigmatic is generative. Rather than a quest for ‘generalisable’ knowledge that is devoid of social context, the knowledge generated through the process of PAR serves empowerment practices and is specifically useful for learning organisations. Migrants’ health is a complex phenomenon that is influenced by macro socio-economic factors of each nation and the unrelenting process of globalisation. Migrant Friendly and Culturally Competent healthcare organisations must be learning organisations. PAR/L requires the learner to work on a real-life project or a work issue and participants have to commit their knowing to action, reflecting on practice, posing questions about what has been
experienced, about what to do differently in the future and so on. Once this learning process has been embedded, the organisation’s knowledge base becomes self-generative. Therefore, ‘what works’ in terms of effectiveness of interventions is the building of the capacity of the MFCC organisation to learn to learn, and PAR/L is undoubtedly the right approach.

**Conclusion** This paper presents a case for the adoption of the PAR/L as an alternative approach to achieving patient and community empowerment. Given the dominance of the bio-medical research orthodoxy and the conventional approach to knowledge production, researchers, managers, and policy makers in MFCC healthcare organisations, and patients and communities who are interested in participatory democracy should seriously explore this option.

**References**


