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Reclaiming the social in community movements: perspectives from the USA and Brazil/South America: 25 years after Ottawa

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SUMMARY

Since the Ottawa Charter 25 years ago, community participation has been adopted worldwide by nation states and communities as a core health promotion strategy. Rising inequities since that time, however, have been largely unchecked in the Americas and globally, and have presented us with an acutely paradoxical time for community participation and action. On the one hand, transnational globalized markets and accompanying economic and environmental devastation have challenged the effectiveness of community action to create health. On the other hand, hopeful signs of local through national and international activism and of new mechanisms for community engagement continue to surface as meaningful and effective democratic acts. This article presents a dialogue on these issues between colleagues in the United States and Brazil, and considers the broader applicability to Latin America and worldwide. We begin by discussing how community participation and community organizing grew out of our respective histories. We consider the catalytic role of the Ottawa Charter in spurring a reorientation of health promotion and the genesis of healthy city and community initiatives, as well as other current community organizing strategies and the growth of participatory research/CBPR. We unpack the potential for co-optation of both community and social participation and end with recommendations for what we can do to maintain our integrity of belief in democratic social participation to promote improved health and health equity.

Key words: community participation; Ottawa Charter; community organizing; health promotion

INTRODUCTION

The Declaration of Alma Ata (World Health Organization, 1978) launched worldwide recognition of community participation within primary care and strengthened its role as a major driver for improving community health. This strategy was later codified in international health promotion through the landmark Ottawa Charter with its call for supporting the conditions in which people can take control and participate in creating healthier lives and communities (World Health Organization, 1986).

Although signed by 26 countries primarily from the industrialized 'first world', the Ottawa Charter, with its reconceptualization of health promotion theory and practice, paralleled a re-emergence of democracy in Latin America

after over a decade of military dictatorships. The 1992 Conference of Health Promotion in Santa Fe de Bogota, Colombia was pivotal in this process. Its representatives from 21 Latin American countries adopted the Ottawa Charter and citizen participation as the basis for realizing democracy and for guaranteeing conditions of population health and economic livelihood. The vast inequities in the region, aggravated by military-political leaders and by macro-economic structural adjustment policies in the 1960 and 1970s, became the backdrop and point of departure for this new health promotion vision (Carta de Bogotá, 2000).

In the USA, the Ottawa Charter has been slower to catch on, though a similar pattern of rising inequities was also underway with the slow erosion of the social safety net and de-regulatory policies under the Reagan presidency of the 1980s. The 1970s had been a period of the most equitable distribution of income and wealth in the USA since the Great Depression. Reagan Administration politics of retrenchment, however, began the growth of concentration of the share of national income in the hands of the richest 1% to its current height, with wages of the typical American essentially static for the past three decades (Reich, 2011).

With this pattern of rising inequities largely unchecked in the Americas and globally, 25 years after the Ottawa Charter, we live in an acutely paradoxical time for community participation and action. Economic and environmental devastation have been engulfing our planet, with globalized financial markets, corporate greed and regional and civil wars conspiring against the ideals of a safe, peaceful and more just and healthy world. At the same time, however, hopeful signs, such as the 'Arab Spring' against dictatorships in the Middle East (Lister and Smith, 2011), and growing global movements for immigrant and refugee rights, environmental justice and so forth have planted important seeds for transformation. Further, local and regional community organizing and participatory strategies for health—the focus of this paper—have been expanding dramatically. Coupled with their role in influencing public policy, such approaches enable us to retain hope that we can live up to the values and aspirations of the Charter.

Multiple developments have been critical in the quarter century since the Ottawa Charter: an important expansion of the definition of health promotion and an integration of community action with public policy; development of the global healthy cities/communities movement based on this expanded perspective (O'Neill and Simard, 2006); the growth of participation in research and evaluation, with action research, participatory action research and community-based participatory research (CBPR) its most well-known terms and the recognition of social determinants knowledge and discourse which strengthens the focus on broader political and policy targets of change. Despite these developments, however, there have been well founded concerns about the potential and actual co-optation of community participation and the limitations of this approach in promoting societal change. In Labonte's words, the newer language of 'social' participation has become defined as a 'protective factor' rather than seen as a movement of civic actors to create more just societies (Labonte, 2009).

This article presents a dialogue on these issues between colleagues in the USA and Brazil, and considers the broader applicability of these issues to Latin America and worldwide. We begin by discussing how community participation and community organizing grew out of our respective histories, from social medicine and social movements in Latin America to neighborhood organizing and social movements in the USA. We then consider the catalytic role of the Ottawa Charter in spurring a reorientation of health promotion and the genesis and growth of healthy city and healthy community initiatives as major examples of this re-orientation, as well as other current community organizing strategies. Next we discuss the more recent growth of participatory research/CBPR and its potential for transformative change. We attempt to unpack the potential for co-optation of both community and social participation and end with recommendations for what we can do to maintain our integrity of belief in democratic participation and hope for our future.

ORIGINS/HISTORY

A brief history of some of the political and economic factors of each region is critical for contextualizing the role that this landmark document has played (or failed to play).

Brazil/Latin America

The politicization of health promotion found in Latin America, and especially in Brazil, a fertile soil for the deepening of new perspectives in this field. These premises had already been debated in the region since the 1980s, when social medicine practitioners and social epidemiologists, pioneers such as Jaime Breilh and Edmundo Granda in Ecuador, Asa Cristina Laurel in Mexico, and Cecilia Donnangelo and Sergio Arouca in Brazil, used theories from economics, sociology and political sciences to identify how capitalist economic systems and social determinants determine profiles of health and of disease both within and between societies (Franco *et al.*, 1991; Barata, 2005; Barradas, 2009). The practices arising from this collective approach contributed to health actions focused on participation and equity, especially those directed to primary health care and local health systems.

It is important to emphasize that the 1980s were marked in Latin America by a period of transition from military regimes to democracy and the intensification of participatory popular movements, which took place in very different ways in each country. In the more highly industrialized countries, the movements occurred initially in urban centers and were more closely linked to the progressive wing of the Catholic Church, the trade unions and those political parties opposed to regimes in power. In more agrarian villages and small towns, actions emerged as 'rebellions'. These popular movements related to land, work, housing, health, education and other basic collective needs, as well as ethnic, indigenous and gender rights. Brazil contained the highest concentration of these movements, perhaps because of its larger territorial extension and population; however, they occurred also in Mexico, Peru, Bolivia, Venezuela and Colombia, among others (Gohn, 1997).

In Brazil, in the early 1980s, popular movements acted independently from and opposed to the State. From 1990 on, the mobilization of civil society with the re-democratization of the country triggered new negotiations with public agencies. New institutionalized participatory structures, institutions, such as community councils for social and health services, and others at the federal, state and municipal levels also emerged and were critical to this process (Cardoso, 1994; Bógus and Westphal, 2007). During the following decades, this form of participation was incorporated into proposals for public policies within various social sectors, among which were those directed to the promotion of health.

USA

Unlike Brazil and Latin America, the decade of the 1980s in the USA began a period of retrenchment of social movements, and within health, the beginning of the individual behavior change revolution. Healthy People, the nation's road map for improving health outcomes, first published in 1976, focused primarily on lifestyle changes to achieve its health objectives. Unlike the Ottawa Charter, the original Healthy People and its descendants (Healthy People 1990, 2000, and, to a lesser extent, 2010), codified health promotion as an educational enterprise focused on nutrition, exercise, tobacco, substance abuse and other risky behaviors, as separate from preventive services (i.e. infectious diseases, oral health and screening) and health protection policies (i.e. injury and occupational and environmental health). To their credit, Healthy People 2010 and 2020 (US Department of Health and Human Services, 2011) took important steps forward, naming the elimination of health disparities (and in 2020, achieving health equity) as overarching goals. The Institute of Medicine followed suit by including in its assessment of Healthy People 2020 five 'leading health indicators' four of which (e.g. the proportion of the population with a healthy environment, and access to health care services) were not focused on the individual (Institute of Medicine, 2011). Although the USA has remained well behind many other nations in its more limited framing of health promotion, these new developments are hopeful. Further, fields such as community health education in the USA have long embraced participation and 'starting where people are' (Nyswander, 1956). In practice, however, interventions often continued to target individuals rather than unhealthy community conditions, and made for less connection with the Ottawa Charter and its Healthy City movements.

Finally, and in spite of the predominant behaviorist orientation within US health promotion, community organizing and participation have had a long and independent history in the USA (Minkler and Wallerstein, 2012). The term, 'community organization' was coined by American

social workers in the late 1800s, in reference to the settlement house movement for newly arrived immigrants and the poor. Yet earlier social movements, such as post-Reconstruction era African-American organizing, and the Populist and Labor movements, were also part of this legacy (Garvin and Cox, 2001). Two overarching US approaches have evolved (Minkler and Wallerstein, 2012; Chavez *et al.*, 2007; Rothman, 2008; Miller, 2009): social action organizing, epitomized by Saul D. Alinsky (Alinsky, 1972) and newer community-building approaches starting from strengths and supporting long-term capacity development (DeFilippis *et al.*, 2010; Wolff, 2010). From the late 1950s on, community organizing has been applied to broader social change, i.e. the civil rights and women's movements; lesbian, gay, bisexual and transgender organizing; disability rights; anti-war organizing and more recently around marriage equality, the rights of immigrants, and environmental and climate justice, to name but a few. Further, larger national organizations like Policylink (2011), have used lessons from effective community organizing to promote equity and healthy public policy at regional, state and national levels.

Within the health domain in the USA, unique contributions supported community participation and empowerment, including citizen boards as a cornerstone of the 1960s neighborhood health center movement (DeBuono *et al.*, 2007). Closely mirroring the Ottawa Charter, the concept of empowerment emerged earlier, as people achieving mastery over their lives (Rappaport, 1984); and was expanded to encompass 'a social action process of individuals and groups . . . for the purpose of achieving social justice and equity' [(Wallerstein, 1992), p. 198]. Interest in empowerment in the USA was also grounded in the popular education approach of Brazilian educator Paulo Freire (Freire, 1970) which gained traction in both low resource countries and the USA and other industrialized nations as a potent approach to community dialogue and participation (Wallerstein and Auerbach, 2004; Su, 2009).

POST-OTTAWA CHARTER TO THE PRESENT: HEALTH PROMOTION AND PARTICIPATION

The Ottawa Charter was a watershed moment in health promotion history and in the recognition of the importance of community participation. Twenty-five years later, the Healthy Cities Movement inspired by the Charter counts ~1000 official community projects, www.healthycities.org, with estimates reaching 15 000 worldwide (de Leeuw, E., Personal communication, 18 April 2011). These projects use intersectorial cooperation and high-level public participation to mobilize resources for healthy municipalities and communities (Norris and Pittman, 2000). The recent celebration of the 25th anniversary of healthy cities at the 7th Global Health Promotion Conference in Nairobi highlighted community empowerment as a continued 'fundamental approach' in health promotion (Fawcett *et al.*, 2010).

The WHO Commission on Social Determinants (World Health Organization, 2008) also has had significant influence in giving scientific credence to the structural inequities that create health disparities globally, as well as identifying the need for policy change coupled with community organizing, from the local through transnational action network scale. Participation itself has been identified as contributing to improved health outcomes (Wallerstein, 2006), with participatory research transforming the paradigm of scientific knowledge creation to include working with in high-level collaboration with community partners. The World Congress on Social Determinants taking place in Brazil, in Fall, 2011, recognized the importance of the global south in promoting these worldwide changes (WCSDH, 2011).

Latin America

While social medicine/social epidemiology and popular democratic movements had their own momentum in Latin America, the Ottawa Charter, as a document of ideas and vision from North America and Europe, gave additional impetus to progressive health professionals as they participated in emerging democratic processes; and, in particular, in the formation of new constitutions with health identified as a universal right. However, the Charter was only one of many influences in the political and economic upheavals taking place in Latin America countries. Some observers indicated that the Charter had significant influence, noting, for example, that '*It has been the inspiring point of reference of the later Chilean movements and policies*;' and that in Uruguay '*the*

Charter has been a fundamental basis for those who work in promotion, education, social participation etc.'

However, for many, the relevance has been more theoretical, or partial. In Mexico, we heard, '*it has certainly had a rhetorical influence since one began the Healthy Cities Network in 1994. However, in fact, no health promotion strategies have been integrated into the health system*.' Similarly, in Argentina, we were told, that '*many of us worked in community health and its promotion years before we had read the Charter; perhaps we have just applied the name to some things we were already doing. Thus it is more of a reference than an influence*.' A like perspective also was expressed in Cuba.

Brazil

In Brazil, too, the Ottawa Charter propositions found propitious ground in the political reforms which culminated in the Unified Health System (or SUS, in Portuguese), the result of a wide mobilization of the Brazilian health movement which started in the 1940s. In the same year as the Ottawa Charter, the *VIII National Health Conference* and its report played a major role in disseminating a broad concept of health, as '*the result of the conditions of nutrition, housing, education, income, environment, work, transport, employment, leisure, liberty, access to and possession of land and access to health services. It is, thus, before all else, the result of the forms of the social organization of production which may generate great inequalities in levels of living*.' [(Brasil, 1986), p. 4] The report influenced the new Brazilian Constitution of 1988 in defining health as a right, a theme dear to the progressive concept of health promotion. Further, it was more emphatic than the Ottawa Charter, in calling for participation of the population in the organization, management and control of health services and actions, represented in the form of a partnership between the National, State and Municipal Health Councils (Brasil, 1986).

It should be underscored, however, that the (re)emergence of health promotion, with the Ottawa Charter's principles and strategies developed outside Brazil, has provoked controversy and debate over the last decade (Campos, 2006). The debate turned especially on issues within the universal and decentralized health system which activated participation in an extensive network of local and national health councils, with members elected to approve annual health plans and supervise implementation of the new health system. In general, council participative mechanisms in health, education and environment were installed as a natural result of the process of political opening and decentralization, but came to be seen as dependent on Brazil's authoritative political culture and the fragility of associative life (Coelho and Nobre, 2004; Bógus and Westphal, 2007). Social participation beyond the sectorial councils was debated particularly regarding how to activate socio-political networks to intervene in the relationship between the State and civil society. The adoption of agendas of local development, among them health promotion and healthy cities, has incorporated, since the mid-1990s, the discourse that participation should ensure that community groups and institutions should act together to identify problems and propose actions for change. This presupposes, above all, a dynamic process in which actors, through their actions and social relationships, construct and negotiate a collective identity that connect members of a movement together (Bógus and Westphal, 2007). In a complementary extension of participation in health promotion, 'participative management' and 'participatory budgeting', in particular, (Cabannes, 2004) have promoted, through local political will and grassroots organizing, increased participation in decision-making and local government accountability. Starting in the 1990s in a few Brazilian cities, most notably Porto Alegre (Sintomer and Marion, 2005), participatory budgeting convenes citizen assemblies in districts to determine priorities for part of a city's revenues, and has been adapted by many cities in Latin America, Europe and Asia, with no single model (Souza, 2001). Systematic criteria however have been proposed. It must have: financial decision-making, especially given limited resources; city level involvement; systematic public deliberation on a repeated basis and accountability as to output (Cabannes, 2004). Even though there may not be consensus as to how the broader health movement within Brasil relates to the Ottawa Charter, there is a strengthening of the idea that 'the SUS and the international health promotion movement share synergistic participatory principles, thus corroborating the idea of the indissolubility of health policies with policies of other sectors, production of health, creation of social actors, and

clinical services' [(Castro and Malo, 2006), p.14].

Brazilian example of health promotion and policy initiatives:
Within Brazil, a convergence of factors led to the formulation of a National Health Promotion Policy (NHPP), which provides an exemplar of how the pillars of the Ottawa Charter—intersectoriality, social participation, integrated public policy and reoriented health services—can be brought together. The election of the leftist President, Ignacio Lula de Silva in 2002, opened up the Ministry of Health to employ new health promotion leaders who started working with other ministries and sectors to devise a broad-based national policy. Coupled with government efforts to support families through expanded primary health centers and economic safety net strategies for the poorest families, the political opening was created for policy change.

Outside government, since the mid-1990s and especially since 2000, Schools of Public Health were also expanding into health promotion curriculum and most notably into centers for research and intervention related to healthy cities, which led to a burgeoning of healthy cities and health promotion networks throughout Brazil. In the year 2000, CEPEDOC (*Centro de Estudos Pesquisa e Documentação em Cidades Saudáveis*) (*Research and Documentation Center on Healthy Cities*) linked to the School of Public Health, University of São Paulo, was created and became a focal point for much of this network development. Today, it is one of the 182 Collaborating Centers of the World Health Organization in the Americas and one of the 21 Centers in Brazil. Similar to the others, CEPEDOC's mission has been to strengthen health promotion through: (i) studies and exchange of experiences in health promotion and healthy cities in Brazil and in other Latin American countries;(ii) technical support for municipalities, communities and organizations in adopting health promotion/healthy city principles in their public policies, programs and actions; (iii) training in health promotion for managers, professional personnel and leaders; (iv) integrated interventions which establish participatory decision-making processes, planning and projects and (v) monitoring and evaluation assessment of policies and models to measure the effectiveness of health promotion actions.

Advocacy, therefore, for an NHPP had strong support from University centers as well as from municipalities and NGOs which were involved in health promotion networks. It took until 2006, however, to implement an NHPP, which ended up as a reduced focus on prevention of risk factors for non-transmissible chronic diseases, alcohol and other drugs, and violence (Brasil, 2011). The Policy succeeded in obtaining funding and has been mobilizing ~1500 municipalities throughout the country. A recent government telephone survey of 991 municipalities (68% of them with fewer than 30 000 inhabitants, 19% between 30 and 100 000 and 9.5% of 100–500 000 inhabitants) and six states reported that: 70.5% of the municipalities have activities in physical activity, 43.9% in violence and traffic accident prevention, 22.7% in healthy eating and 10%, other. Almost all reported undertaking these activities jointly with health service units. While the assessment of the effectiveness of the Policy demonstrated positive results regarding risk factors, there seemed to be little contribution to community capacities, social participation, other sector public policies and sustainability of municipal experiences. These broader efforts in health promotion, therefore, are still falling to entities external to the national government, i.e. universities, NGOs, public health professional societies and local municipal efforts. In 5 years since the Policy's approval, it has been disseminated over a range of municipalities, and is proving fertile ground for the continuation of the health promotion debate in Brazil.

USA

Reflecting in part its unique political economy emphasizing individual responsibility and 'market justice' rather than the common good (Wallack and Lawrence, 2005; Robertson and Minkler, 1994), the USA has historically had less connection to the Ottawa Charter and the approach it represents. While some states (key among them California, Colorado and New Mexico) have placed a strong emphasis on the development of healthy cities and communities (Norris and Pittman, 2000; Kegler *et al.*, 2009) this approach has not yet reached its potential in the USA. Partially in response to funding requirements, including federal mandates in the 1960's for 'maximum feasible participation' in health planning and more recent government and philanthropic calls for 'community engagement' and participatory planning in health councils, there has been an increased focus on community participation in the health sector. This often has led to dramatic improvements in the design and implementation of health and health care programs and policies, from the early Neighborhood Health Centers (DeBuono *et al.*, 2007) to multi-faceted and locally-driven community-health department programs in low resource neighborhoods (Ellis and Walton, 2012). On a larger scale, national organizations like PolicyLink, headquartered in Oakland, CA have helped 'lift up what works', TM using the lessons from community building on the ground to help effect policy change at regional, state and national levels. Similarly, both nationally and in states like California, new initiatives promoting 'Heath in All Policies' (HiAP) are urging that all proposed new laws

and policies in land use planning, transportation and other areas be considered in terms of their potential health impacts prior to approval (Rudolph *et al.*, 2010).

We also are seeing increasing appreciation of the importance of broadening our gaze beyond individuals to communities and broader systems. Prestigious bodies such as the Institute of Medicine (Institute of Medicine, 2011) and Foundations such as Robert Wood Johnson have adopted WHO Commission on Social Determinants frameworks to emphasize community collaboration and empowerment as essential tools for eliminating health disparities. Community empowerment, community participation and community partnerships similarly 'are among a litany of terms used with increasing frequency by health agencies, philanthropic organizations, and policymakers' (Minkler, 2012). Although the reality of the accent on community has not begun to match the rhetoric (DeFilippis *et al*., 2010), clear movement in this direction is evident. Community coalitions around multiple health issues have exploded in recent decades (Butterfoss and Kegler, 2009; Wolff, 2010). Local communities have mobilized to fight environmental racism; food insecurity and obesenogenic built environments; HIV/AIDS; the targeting of youth and communities of color by the tobacco and alcohol industries and cutbacks in basic social services for vulnerable groups.

Finally, a growing interest in CBPR in health has brought community organizing principles into the domain of research, challenging more traditional 'outside expert'-driven approaches to 'equitably' engage community partners throughout the research process, build local capacity and 'balance research and action' (Israel *et al*., 2005; Cargo and Mercer, 2008; Minkler and Wallerstein, 2008; Horowitz *et al*., 2009). The National Institute of Environmental Health Sciences (NIEHS) became the first of the National Institutes of Health to support CBPR in the mid-1990's (Mercer and Green, 2008). By 2010, well over half of the NIH's institutes and centers were supporting research using this approach, as was the Centers for Disease Control and Prevention (CDC) and numerous philanthropic organizations. Yet even without such outside support, partnerships between communities and academic and health department partners were being forged, as researchers recognized the need for genuine community partners as a prerequisite for addressing health disparities in marginalized communities, and these communities in turn sometimes approached academics to help them address pressing local health issues. Community-Campus Partnerships for Health (www.ccph/info) became arguably the most widely known and respected US-based organization for helping build and maintain such partnerships, in part by helping universities create 'portals of entry' and other mechanisms through which communities could approach these 'engaged institutions' for partnerships.

LIMITATIONS OF COMMUNITY PARTICIPATION

As a discourse incorporated worldwide, participation has come to be understood in recent years as a process which advocates for the strengthening of transparency and accountability of public institutions; of community capacity development and problem-solving and, of enhanced democratic processes at local through national levels. However, this process is not linear. There are many contradictions in participation of community members within public and political spheres. A continual question is whether people should participate through government in formulation of public policies (which at best often leads to only small and incremental change), or participate in social movements and advocacy to pressure a reluctant State to 'do what's right' in promoting the health and well-being of its people. One must also take into consideration that participative processes depend fundamentally on the political processes underway. If the government is authoritarian, participation may be used to legitimate or co-opt outcomes in the quest for a consensus on political decisions. If the public sphere is more democratic, conditions may support participation as the basis for political action (Mendes, 2008).

Yet despite democratic discourse in which participation is prized, whether through formalized structures within government processes, or from outside social movements which apply political pressure for change, there are continual challenges to the creation of spaces for participation and negotiation of conflicts. If a society has profound inequalities, citizen participation may be equally marked by social inequalities for people who have been historically

marginalized or discounted (Marmot, 2007). Corporate or other organized interests will have more influence on policy creation and implementation than the population which can play but a secondary role. And not all organizing or social movements are health promoting. Community organizing approaches such of those of organizer Saul Alinsky (Alinsky, 1972), for example, have been co-opted in the USA and used to support causes which may be antithetical to the public's health and well-being (Minkler, 2012; Vogel, 2010).

Within public health and health promotion, community participation in planning, interventions and research, supported by Ottawa Charter rhetoric, has been increasingly identified as health-enhancing in and of itself. This may be through indirect pathways of enhanced social support and empowerment, or through directly organizing against unhealthy conditions (Wallerstein, 2006). Within community processes around health, the World Bank has identified four characteristics to ensure that participation is empowering: people's access to information on public health issues, their inclusion in decision-making, local organizational capacity to make demands on institutions and governing structures and accountability of institutions to the public (Narayan, 2002). Rifkin has added the important factor of human rights (Sen, 2001; Rifkin, 2003). Yet, within these community-based processes, which often are initiated by outsiders to the community who may be naive about local contexts and conditions, participation effectiveness may be constrained (Tandon, 1988; Campbell and MacPhail, 2002). Participation can be manipulative and passive, rather than empowering and based on community control (Arnstein, 1969; Rifkin, 1990). It can be viewed as utilitarian, i.e. to assure program efficiency (Morgan, 2001); limited, i.e. engaging community members as no more than informants (Cornwall and Jewkes, 1995) or may obscure the need for analysis of larger institutional structures and policies which can override local determinants of well-being (Francis, 2001). As Foucault has argued, there is a danger of accommodating people to their relative powerlessness rather than challenging the hierarchies that create it (Foucault, 1980; Labonte, 2009).

In addition, Labonte has cautioned us to be wary of interventions which advocate for social capital, social cohesion or other forms of social inclusion, which might by default manipulate participation toward joining the status quo, versus social movements that embrace important moments of conflict to challenge socio-economic systems that replicate inequities (Labonte, 2009). Labonte advocates not being so concerned with social exclusion of groups *per se* that we miss the larger task of countering the socio-economic and political powers that have created the excluded groups and conditions in the first place (Labonte, 2009). As he goes on to suggest, however:

> [we need to] learn how to dance the dialectic, and not discard the hopefulness that infuses the social inclusion/social exclusion concept. The dialectic dances between seeking to include more people into social systems stratified by exclusion even while trying to transform these systems. It's an old dialectic, one that never fully resolves but remains at best a grapple-able task, one that straddles the imperatives of revolution with the pragmatics of reform. [(Labonte, 2009), p. 276].

And within this dialectic, we search for strategies to promote empowering participation, such as community decision-making and control over project funding (Duran and Duran, 1999), support for emergent leadership (Gutierrez and Lewis, 2005) and procedural justice, where new community voices are included in policy-making venues and who can advocate for change at a higher level (Minkler, 2010).

FUTURE AND CONCLUSION

What to say about the future? First a call to open our hearts. At the societal level, we have as Raphael has pointed out, a global 'neo--liberal resurgence in public policy' (Raphael, 2008). The polarized global marketplace of supply and demand for products, services, marketing and ideologies is increasingly excluding social needs and ethical-political priorities from the debate as ingredients of lives that are worth living. For the future, we must undertake a rigorous challenge to the imperative of individualism, and make efforts to rescue collective action as a valuable scope and sphere of human life. We can see this need from both the examples of the USA and Brazil.

In nations including the USA, health promotion frequently is reduced to a focus primarily on 'the holy trinity of tobacco use, diet, and

physical activity' [(Nettleton, 1997), p. 318; see also (Raphael, 2008, 2010)]. With the highest level of unequal income and wealth since the great Depression in the USA (Reich, 2011) and in the difficult economic times that followed the Great Recession of 2008, we cannot expect poor and low-resource communities to thrive without substantial external resources and support (Hyatt, 2008; DeFilippis *et al*., 2010). Therefore, how do we accompany 'individual responsibility for health' with community 'response-ability' by refocusing on social determinants and healthy public policies (Minkler, 1994)?

In Brazil, the social scientist, Ruda Ricci, expressed the dialectics of the debate well by stating that:

> the moral energy that generated social movements in Brazil in 1980 was avowedly libertarian and autonomist. From this wave was born participatory committees within the state and various other tools of deliberative democracy. However, in the twenty-first century, this power has splintered into many agendas and led to the advancement of a paternalistic state as solely a protection agency. The joint public health and social protection of the Brazilian Unified Health System was the exception from this regressive panorama. The question remains: what to do to resume an offensive for control over national, social and democratic transformation of the state? (Ricci, personal communication, 2011).

Even though it is recognized that the existing conflicts and difficulties may restrict the processes of social change, one cannot ignore what Boaventura Souza Santos affirmed over a decade ago in Brazil, but with worldwide applications: that our historic experiences provide the elements for various reconstructions, among them those involving the concepts of democracy and citizenship (Santos, 1999). Through such affirmations, the principle of community is given greater value, and with it the ideas of agency, equality, autonomy and solidarity. Consistent with the Ottawa Charter's message of over a quarter of a century ago, this implies renewed commitments of public interest and the redefinition of the role of the State and of society. Within this renewed affirmation, broad, health-promoting social policies are developed, and historically marginalized peoples have new and expanded forums for meaningful participation in creating conditions of greater health equity for all.

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