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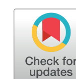
Review Paper

History in health: health promotion's underexplored tool for change



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ABSTRACT

Objectives: This paper outlined an argument as to why history and historians should be included in a healthy settings approach.
Study design: Qualitative descriptive study.
Methods: A narrative review of the literature across a broad cross-section of history, health promotion and public health disciplines was undertaken.
Results: Three reasons for including history were identified relating to the social role of history as a means of analysing social memory, of changing social narratives and by raising social consciousness. This allowed for a distinction between history *in* health and history *of* health. Precedents of this social role can be found in the fields of feminist and postcolonial histories, oral history and museums in health.
Conclusion: Reasons for why historians and health promotion practitioners and researchers have not previously had working relationships were explored, as were some of the factors that would need to be considered for such relationships to work well, including the need to recognise different languages, different understandings of the role of history, and a potential lack of awareness of the health implications of historical work.
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Introduction

Change is a fundamental tenet of health promotion and is at the heart of the Ottawa Charter's key action areas of developing healthy public policy, creation of supportive environments, strengthening community action, development of personal skills and reorientation of health services.[1] While health promotion practitioners and researchers have drawn on multiple disciplines and sectors in their quest to implement personal and societal change towards health and wellbeing, there is one discipline that has rarely been called upon. History. In this paper, I examine the literature to outline why and how history has been underutilised in health promotion and consider the possibilities history presents. I draw on Sheard's[2] phrase, history in health, and on various precedents and practices to argue history that deeply analyses the sociopolitical structures and processes and which challenges the myths of our inherited wisdoms and narratives, can be a useful tool for health promotion. There are some caveats to this argument that I will explore throughout, in particular in regards to notions that history is never value-free and thus, needs to be used carefully and thoughtfully.

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First a word on terminology. History is a discipline with which historians identify. Most historians would also recognise 'history' as meaning a product or story as told by a historian, drawn from systematically analysing and interpreting events and documents from the past to provide meaning.[3] Traditional historical research is undertaken though a rigorous process of identifying authentic and relevant primary sources (data produced at the time of past events) and analysing these to identify points of agreement/disagreement from which to construct a meaningful narrative.[3] However, common usage of the word 'history' conflates the story with the past itself. Throughout this paper, I use 'history' to: 1) describe the discipline and practice of undertaking historical research; as well as 2) the interpretations of past events and factors as found in a historical product, such as a book. As such, I recognise that 'history' incorporates multiple stories and is rarely singular or uncontested. I also recognise 'health promotion' has had various meanings, theoretically and in practice.[4] Throughout this paper, I refer to health promotion as detailed in the Ottawa Charter.[1]

Finally, I wish to declare my own position. I have undertaken historical research for some 20 years as well as worked as a health practitioner and academic. Recently I have become increasingly interested in more practical uses of history as an intervention for health promotion. This paper places that interest in the context of the health promotion literature, specifically the settings approach which is appropriate for exploring history both as contributing to understanding contexts, and as a tool or intervention. Thus, this paper is a narrative review of the literature that has sought to identify how history has been used in health promotion settings approaches, and how it could be used.

Acknowledged but omitted

The settings approach for health promotion is an attempt to operationalise the Ottawa Charter and shift the focus away from a deficit model of disease to one that capitalises on the inherent strengths of place.[5] Poland, Krupa and McCall[6] argue that the settings approach means addressing the contexts in which people live, work and play and a detailed analysis of the context should include: who is there; how they think or operate; implicit social norms; hierarchies of power; accountability mechanisms; local moral, political and organisational culture; physical and psychosocial environment; and broader sociopolitical and economic contexts. One of the questions they recommend is, 'what is the history of health promotion in the setting?'. While this is a useful question, it misses a more important influence—that of the history of the setting itself. Poland, Krupa and McCall[6] imply historical influences will become apparent through understanding the present context, but this assumes a level of historical consciousness few communities would have; that is, that they are aware of the influence of their own past.

It is this implication, but rare explicit detailing, of historical context that characterises much the healthy settings approach. The six principles of sustainable healthy settings approach outlined by Poland and Dooris[7] include: adopting an ecological 'whole systems' perspective; starting where the people are; rooting practice in place; deepening the sociopolitical analysis; taking an asset-based/appreciative inquiry approach; and building resilience. Most of these imply an understanding of historical influences. For example, an ecological 'whole systems' approach—that is, understanding the interdependence of all factors within a social, economic and environmental context—necessarily includes acknowledging past influences; and a sociopolitical analysis should uncover how past power differences and patterns have become entrenched in our current social structures and processes. In understanding practice rooted in place, Poland and Dooris[7] acknowledge the unique confluence of culture, structure and history as communicated through policies, agendas and biographies related to a particular setting. However, the literature is not clear about how these past influences are made overt or analysed to contribute to health promotion strategies in a settings approach. There is an acknowledgement of history, but little in the practical uses of history to contribute to change.

There are three ways that history can contribute to change within a healthy settings approach: analysing social memory; changing social narratives; and raising social consciousness. Social memory refers to understanding the embedded power structures within institutions and communities that work to reinforce and re-produce the status quo. Feminist and postcolonial histories have focused on revealing such power structures, including patriarchal, capitalist and nationalist ideologies. These have sought to give voice to constituencies who have had little place in the historical record.[3] This process of writing marginalised and disenfranchised voices back into the past contributes to changing the social narrative; of recognising the experiences, knowledge and contributions of non-elites.[8] Dooris[9] acknowledges the importance of 'bottom-up' developments in health promotion, in creating a groundswell leading to political action and draws on Freire's[10] conceptualisation of raising social consciousness, a mediating process involving development of critical consciousness through social analysis of conditions and people's roles in bringing about transformational change.[11] Such analysis needs to be historical because the social institutions and processes that determine those conditions emerged from the past. The social memories and social narratives reflect and reinforce the dominant and privileged such that those who are oppressed or marginalised may not realise their own status.[10] Thus, my argument throughout this paper is that historical research can peel back the layers of social memories to reveal the mechanisms that directly influence social conditions; that historical processes and products can be used to change social narratives and social consciousness and that these work as feedback loops to influence social memory. This, of course, necessitates understanding history as part of 'whole systems' thinking, which is consistent with healthy settings approaches in health promotion.

Historians have always thought in 'whole systems' that are used to deal with complexity and how the past determines the present.[3,12] Unfortunately, there has been a gap between historians and health researchers and practitioners.[13] This has been partly due to many historians taking a 'history for history's sake' attitude that distances historical research from social and political needs.[3] Histories produced from this

perspective examine the contexts extensively and are consistent with 'whole systems' thinking, but they contribute little to understanding current social problems and issues. Worse than that, such histories have often been (mostly inadvertently) guilty of reinforcing social structures that have marginalised and disenfranchised people.[13] McGrath[13] argues that although history has the potential to promote well-being by challenging social structures and myths, history is never value-free. That is, despite claims of objectivity by many historians in the past, historical research is influenced by the worldview of the researcher. Thus, McGrath[13] urges historians to work collaboratively with health researchers so their considerable skills and knowledge around context and 'whole systems' thinking can complement those of health researchers and practitioners, who in turn can help historians become more aware of the health impacts of history.

Not history *of* health

While a small number of historians are becoming more mindful of health as a field of research, I wish to draw a distinction here between history *in* health and history *of* health. The well-established history of health field includes histories of medicine and medical technologies, but also histories of public health, such as written by Porter,[14] Berridge,[15] Hardy,[16] Borsay[17] and Szreter.[18] While few of these historians would have a 'history for history's sake' attitude, there is an argument not enough has been done to help health researchers and practitioners understand the relevance of history for current practice. It is telling that in writing the forward for *History of social determinants of health*, Marmot[19] notes how shocked he was at the attitude of historians regarding not using the past to learn lessons for the present and the belief the past does not repeat itself. He, instead, chose to think about social conditions as contingent on the past and that the past can help us change the social conditions and thus health outcomes.

The argument about the relationship between the past and the present has been evident for years within the history discipline: from those who believe 'history for history's sake' to those who believe history has a definite social role that relates to the present.[3] That social role includes challenging myths and offering alternatives, informing current debates by highlighting how ideology can determine the questions being asked and the priorities being set, and contributing to current problem solving.[3] Gaddis[12] adds that taking lessons from past events and conditions does not mean forecasting, so historians will not try and predict the future based on the past, but recognise the past for what it is and what it offers in the present—understanding and insight, not predictions. Gaddis[12] suggests historians can alter perspectives; that the products they produce may help those who read or view them to 'revise their own views so that a new basis for critical judgement emerges, perhaps even a new view of reality itself'. Thus, historical research and products may help free marginalised and oppressed people from silence, from the tyrannies of judgements imported from other times and places, from determinism and the conviction that things could only happen as they did.[12] Zinn[20] claims history does this through five ways: 1) widening our view to include silent voices of the past, so we can look behind the silence of the present; 2) illustrating the foolishness of depending on others to solve problems of the world; 3) revealing how ideas are socialised into us by the powers of our time; 4) inspiring us by recalling moments of the past when people behaved differently and so prove it is possible; and 5) sharpening our critical faculties so that while we act, we think about the dangers created by our own desperation.

History *in* health is founded on this understanding of history's social role. Sheard[2] argues history is a means of increasing social consciousness, and that there is a need to consolidate history as an essential tool within health. She particularly focuses on the analytical tools historians can bring to contemporary health policy-making, helping to tease out differences between fact and fiction, and bringing long-term perspectives and analyses. Sheard[2] also emphasises the need for local history and oral history as ways of rooting people in place and strengthening social capital. Thus, history in health is a more active and local interpretation of historical research and practice. It is one that seeks to analyse the deep social and political processes and structures that influence present-day contexts. It challenges present-day narratives that continue to silence and marginalise people and presents examples from the past that demonstrate alternative narratives. It can provide an avenue of practice through bringing people together to develop a collective story of their own, one that is empowering and supportive of well-being as opposed to one of victimisation or helplessness. It is this active and local interpretation of historical research and practice that could benefit those working within a healthy settings approach.

Precedents and practices

In many ways, history in health has its foundations in the more established fields of feminist and postcolonial histories that have found expression in a variety of outlets, including subfields of oral history and museums in health. All have similar goals: of raising social consciousness around issues of inequity; and how cultural institutions and practices can contribute to community development and well-being.

Oral history has been extensively used in feminist and postcolonial histories because of the lack of archival documents related to women and First Nations people that were not produced from a privileged white, male perspective.[8] A range of marginalised groups have also found oral history provides them with an avenue to have their voices heard as communities (see for example, reconciliation in South Africa[21] and the history of queer Latinos and Latinas living in San Francisco[22]). Community oral histories, undertaken by community members, have the potential to bring people together to develop a shared sense of identity and build capacity, provided they are undertaken in a way that does not collapse into nostalgia or uncritical celebration of a limited perspective of the past.[23] My own[24] reflections on the collaborative skills and processes associated with a rural community oral history project—of increased community participation, negotiating representation issues, developing

shared decision-making and building community trust—suggest these can increase community resilience and have a role in developing healthy communities.

Similarly, museums can legitimately make claims to social agency through the creation of cultural identity and engendering a sense of place and belonging.[25] Shunning the image of museums as static, dust-collecting displays that reinforce the status quo, Sandell[25] advocates museums have a social responsibility of combating social inequality. Museums do this through: community regeneration and renewal initiatives; community participatory spaces; capacity building; and excluding stereotyping and silences. In challenging the tendency of museums to represent and reinforce privileged values and structures,[26] especially in countries with colonial pasts,[27,28] museums in health, as an emerging field of study, helps recover the past as part of a process of identity (re)-construction.[29] Abram[30] argues history and historical consciousness is central to civil society because it is fundamental to identity. She notes traditionally museums have not helped the public see history's practical use or relevance by avoiding controversial issues and not challenging myths. She contends that museums can find ways to establish dialogue that crosses class, race, religion, age and national origins, and that historical sites can be powerful places of engagement with issues of identity. Examples include exhibitions that have challenged the place of disabilities in society,[31] representations of lesbians and gay men[32] and racism related to migration.[33] Thus museums can challenge narratives of inequity and inequality and help shift broader social narratives to be more inclusive.[34] These narratives are not necessarily place based and thus can contribute to several healthy communities agendas that are place and/or identity based.

These examples point to several practical uses of history in health for health promotion. First, history can raise social consciousness through: giving voice to those whose place in history has been overlooked and whose present social role has been under-represented; and in publically portraying injustices and inequities. In doing so, this can lead to changes in social narratives and illustrate the structural barriers that need to be overcome to develop more inclusive communities. Second, community oral history projects provide an avenue of participation and engagement that opens opportunities for community members to: learn skills in communication such as interviewing and writing; build trust and a shared sense of identity and belonging as they negotiate diverse perspectives. These practical uses of history in health strongly reflect the principles of the settings approach outlined earlier. They also point health practitioners towards developing partnerships with their local historical societies, oral history associations and museums.

Conclusion

Throughout this paper, I have used the phrase ‘history in health’ to denote a particular way history research and practice could be used within a health promotion settings approach. I have highlighted the arguments around history's social role and why this can contribute to a health promotion agenda. The past cannot be changed, but we can change the way we understand that past and the way we use the investigations and products of enquiries into the past. As health promotion researchers and practitioners, we need to be working in partnership with a wide range of disciplines as part of multi-strategic and multi-sectoral interventions to address social determinants of health. History has been underutilised in this venture. I have outlined a number of reasons why and how history and historians can be more readily brought into the health promotion fold: as experts in analysing deep sociopolitical contexts, including structures and processes that exclude; as tellers of stories that can shift the social narrative towards well-being; as myth-busters that can help the silenced find their voice; as contributors to raising social consciousness. I have also suggested projects such as community oral histories that can provide avenues of community participation and engagement that can work towards a more inclusive community. As such, I urge health promotion researchers and practitioners to build partnerships with their local historians and museums, although I add two cautions: 1) to be aware of different views amongst historians regarding the social role of history; and 2) to recognise many historians who may not be aware of the health impacts of their own work, and thus may need to be coached around health promotion interventions and the ethics of working in communities. I add these cautions, not to be critical of historians, but to alert health promotion researchers and practitioners to a possible naivety about health promotion work within some historians. There has not been sufficient dialogue between the two disciplines over time for each to fully understand the other or how each can make the most of the skills and knowledge of the other. As a historian and health researcher, I trust this will change and that health promotion practitioners and researchers will come to see local historians as a valued partner in healthy settings approaches and that the role history can play in healthy settings will become more overt.

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