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Social Comparison and Perceptions of Health and Illness

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One of the most striking features of the journey from health to illness and back again to health is the nearly constant presence of uncertainty. What caused the problem? Is it serious? Is treatment necessary? Is a given diagnosis accurate? How long will recovery take? How effective is this treatment? These are but a handful of the questions that have likely demanded the attention of anyone in physical distress. Presumably, the best answers to such questions are provided by health professionals. Nonetheless, it is far from uncommon to observe these queries being directed to and answered by family, friends, and even strangers, few of whom have any well-founded idea of what they are talking about. Furthermore, it does not tax the imagination to assume that the practice of having laypeople reduce each other's illness-related uncertainty can have serious consequences. People may exacerbate a problem by persisting in behaviors condoned or encouraged by others; they may postpone treatment until it is too late, having been told by others that treatment is either hopeless or unnecessary; they may discontinue an effective therapy, impressed by the negative reactions of their friends; and so forth.

The following material is an initial exploration into the dynamics of acquiring medically relevant information from unqualified sources. Chief among the issues to be considered are: (1) How common is the use of nonexpert opinions for clarifying illness-related uncertainty? (2) Why do people seek nonexpert opinions, and why are others willing to provide them? (3) What are some determinants of the likelihood of seeking nonexpert information? (4) What are the possible influences of nonexpert information at various stages of illness and recovery? (5) What determines the actual content of nonexpert information? and (6) How does the influence of nonexpert information interact with attempts to modify health care behavior?

Due to the scarcity of previous research specifically aimed at these issues, much of the discussion is somewhat speculative, although relevant data and theory are supplied when possible. Consequently, the reader is advised to approach the material with the aim of uncovering problems that may otherwise have remained hidden, rather than of finding firm answers to long-standing questions. This is not to say, however, that this chapter is simply fuel for future research. The ideas presented often have direct implications for layreaders and students as they are involved in the process of nonprofessional information exchange and for health professionals as they are affected by it. These implications are spelled out at the end of each section.

As an organizing framework, the issues to be explored are viewed as instances of the general process of *social comparison* (cf. Festinger, 1954; Suls & Miller, 1977). This term refers to the tendency of people to evaluate various aspects of themselves through a comparison of their own characteristics (opinions, feelings, behaviors) with those of other people. In the following discussion, it is assumed that people often have mixed feelings concerning their health status and what to do about it. The resulting ambiguity and ambivalence can be resolved by hearing others' opinions and deciding that those feelings shared by others are more valid than the remaining nonshared impulses. For example, a person may want to see a doctor but be afraid of the cost. The cost factor will play more (or less) of an inhibiting role to the degree it is emphasized (or overlooked) by others. Thus, the appropriateness of being concerned about cost has been clarified through social comparison. In general terms, then, the act of seeking medical information from nonexpert others can be seen as yet another example of the pervasive practice of using comparison information for self-evaluation and self-direction.

FREQUENCY AND IMPACT

The concept of a "lay referral structure" (Friedson, 1961) or "lay conferral system" (Elder, 1968) has attracted the attention of medical sociologists for the last 2 decades. This concept describes an informal community-based network of individuals, most of whom are not medical professionals, whose function is to provide medically relevant information in the form of diagnoses, treatments, and professional referrals. Available data indicate that this is a very active and influential network.

Suchman (1965) reported that unusual physical symptoms were followed by lay consultation in 74% of his sample and that 16% of the sample talked with two or more nonexpert others. Lay conferrals were felt to have provided a fairly clear course of action by 78% of the respondents, and over 70% described others' opinions as highly influential in determining subsequent action. Similarly, Miller (1973) found that early signs of head and neck cancer prompted discussion with

medically uninformed consultants 62% of the time and that in 55% of these instances others' opinions became the guide to action. Davis and Eichorn (1963) asked cardiac patients whether they had asked for others' opinions of their doctor-prescribed recovery and prevention regimen. Over 90% of the sample answered in the affirmative, and 52% said they were more influenced by the opinions of family and friends than by their physician's advice. Twaddle (1969) observed that symptoms resulting in great pain or sudden disability prompted doctor visits without lay consultation, but that other symptoms, constituting the majority of cases, triggered a series of nonexpert discussions, with the typical subject consulting others until finding one that recommended professional attention. If no such advice was received, the symptoms were usually ignored until they became much worse. Heinzelmann and Bagley (1970) studied the decision of potential cardiac victims to participate in a preventive physical activity program. They noted an 80% participation rate for subjects whose spouse had a positive opinion of the program, whereas only 40% participated if their spouse's attitude was neutral or negative. Osterweis, Bush, and Zuckerman (1979) found that the best predictor of patients' adherence to prescribed medicine-taking was the extent to which other family members used medicine. If others did not believe in the validity of taking medicine, adherence was extremely limited.

In order to get an even clearer idea of the magnitude of the lay referral system, I had 220 undergraduates complete a health questionnaire. It first asked how often in the last year they had experienced unusual physical symptoms with mixed feelings and no ready explanation. The main response was 2.4, or about once every 5 months, with only 6% indicating no such occurrences. On the average, each time uncertainty-provoking symptoms were experienced, 2.7 non-experts were consulted, and their advice or opinions had a strong directive influence on reactions to symptoms in 68% of such discussions. Furthermore, subjects had an average of 1.8 instances in the last year of being given medical advice by laypersons without having asked for it. The typical subject reported having offered medical opinions and advice to 3.2 others a total of 5.5 times in the last year (the distribution on this item was sharply bimodal, with roughly a third of the sample rarely or never giving advice and the remainder doing so every 1 or 2 months). Only 13% of the sample reported they would not offer any opinion due to their lack of expert information if consulted by others with medically related questions.

In general, subjects reported seeing a doctor to inquire about symptoms .9 times, or about once every 14 months. Whereas professional advice concerning home treatment, recovery, and/or future prevention was obtained in 74% of these cases, nonexpert opinions were sought 88% of this time, and unsought advice and opinions were offered by others in 5 out of every 10 instances. Additionally, subjects felt that lay information was *at least* as influential as professional information in determining their feelings and actions in 65% of their postdoctor-visit experiences.

Finally, on an overall basis, 81% of the subjects said that they consulted with others in order to clarify their own feelings and decide on a course of action, as opposed to just wanting to vent their own feelings, obtain reassurance, or gather support for decisions they had already made. This last finding again suggests that the lay conferral system plays an active and influential role in shaping perceptions of health and illness. There seems to be little doubt, then, that consultation with nonexpert others is both a common and important aspect of the experience of illness.

Implications

Laypersons. Seeking and offering medical advice is apparently commonplace among the medically uninformed. As such, these activities are most likely acceptable and perhaps even expected. People should therefore not hesitate to seek the opinions of lay consultants because these opinions will usually be readily offered and failure to accept them will typically result in prolonged ambivalence and inaction. Similarly, laypersons need not be too hesitant about offering medical advice to others (particularly if one has special experiences that may be relevant) because such advice is probably desired and will probably be obtained from others if not from oneself. People should also be aware that failure to engage in lay consultation may be interpreted as indifference, lack of respect, and so forth (rather than prudent silence in the face of ignorance) due to the readiness of most people to participate in the lay conferral system.

Health Care Professionals. These data should make it clear that medical personnel and their patients do not interact in a vacuum. The factors that bring patients to professionals and mediate recovery and prevention are by no means confined to a strictly medical domain (cf. e.g., the findings of Zola, 1973, that various types of physical symptoms are in and of themselves unrelated to the decision to see a doctor). Rather, the health care professionals must take into account the fact that their patients' feelings and behavior are strongly influenced by information received from nonexperts and that such information can obviously be at odds with the professional's intentions. Particularly in troublesome cases, some effort should be devoted to determining what information, if any, the patient is receiving from uninformed others and to understanding that the patient is being influenced by this information rather than by medical factors alone.

THE IMPETUS FOR LAY CONFERRAL

Although lay consultation is clearly an extensive and influential practice, it is not readily apparent as to why this is the case. Few people would deny that good health is one's most important asset and that improper health care can create

life's greatest disasters. It is also clear that medicine is an enormously complex discipline, requiring more years of intense study and practice than most other professions. How, then, can people be interested in and influenced by the medical opinions of others who have no such training and who are capable of delivering a large variety of potentially harmful or even fatal misinformation? At least intuitively, one would be rather hesitant to seek or heed the advice of an uninformed layperson if it pertained to investing life savings or fixing electrical malfunctions. Yet people seem ready to literally play with their lives and well-being in a game of unfounded medical opinions.

By the same token, it is also odd that people are willing to offer medical advice. Again intuitively, it seems that if one knew nothing about cars and was consulted about a problematic carburetor, the most likely response would be to claim ignorance, not to suggest a gas-treatment product or urge a costly and time-consuming visit to a mechanic. Nonetheless, even deeper ignorance of the causes and implications of symptoms, of the validity of treatment techniques, and so forth fails to inhibit people from offering health care suggestions with sufficient confidence to render them influential.

The following sections attempt to explain the high frequency of lay consultation, although the absence of much relevant data results in a good deal of pure speculation. Attention is first focused on the recipients of nonexpert information and then on its providers.

One of the central points made by Festinger's (1954) theory of social comparison is that when an objective basis for defining reality is not easily available, people will rely on a social definition of reality produced by mutually shared opinion. For example, it would be difficult to decide via purely objective evidence that one is creative, so one either "is" or "is not" creative as a function of a social consensus. In this manner, it may be that the great complexity of the medical domain, which should remove it from the influence of uninformed opinion, instead gives it the appearance of being difficult to define objectively, and thus leaves it susceptible to social definition. If it is felt that there is no definitive objective basis for knowing the meaning of a symptom or the efficacy of a treatment in any single case, then these matters will tend to be "known" by the opinions of others. That is, if no person can prove medical reality objectively, then every person is entitled to his or her say. In contrast, less involved matters, such as investment plans, electrical systems, or auto mechanics, are probably viewed as subject to objective definition—there is a right and a wrong, and it can be proved which is the case—and therefore, nonexpert opinions would be neither sought nor heeded. This reasoning leads to the expectation that other highly complex areas, such as interpersonal relations and mental disorders, would likewise be seen as defying objective definition and consequently susceptible to lay consultation. The bottom line here is that nonexpert opinions may be sought and heeded in medical matters because health care professionals themselves are viewed as nonexperts in the sense of lacking objective bases for their opinions.

A second reason for initiating and responding to lay consultation could involve the frequently high costs of relying on expert information. These costs can include: (1) time and effort (e.g., it will usually be easier and faster to consult family, friends, or colleagues than to see a doctor); (2) ease of disclosure (e.g., it will usually be more comfortable to discuss personal problems with familiar others than with a relatively unknown and possibly unsympathetic health professional); (3) pain and discomfort (e.g., lay consultants will probably be far less likely than professionals to recommend painful or difficult medical tests and curative or preventive procedures); (4) bad news (e.g., nonexpert others are probably motivated to avoid giving unpleasant information, cf. Tesser & Rosen, 1975, whereas professionals are bound to do so if the case merits it); (5) re-priming (e.g., familiar others are probably less likely than professionals to chide the subject for bad health habits or failure to follow advice); (6) commitment (e.g., people may feel at liberty to disregard the opinions of lay consultants if they are not pleased with what they hear, whereas seeking professional information tends to commit one to abiding by their opinions); (7) individuality (e.g., people are likely to feel they are a unique and important object of concern when presenting their problems to familiar others, whereas the constant stream of cases handled by professionals may produce in people a sense of being a mere slot in the schedule book and of no great moment, lost in the crowd of patients rather than the center of attention); and, last but not least (8) money (e.g., seeking professional information often introduces the vivid possibility of major or even ruinous expenses). In short, cost considerations suggest that people may use lay consultants to reduce medically related uncertainty not because they necessarily value such opinions but because they fear the consequences of consulting professionals.

A third factor promoting lay consultation may be a desire to avoid or minimize responsibility for important decisions. There are many ways in which people can appear foolish (or worse) to themselves and others when subjected to possible or real illness. If they take too much action, they may appear hysterical or hypochondriacal. Too little action would constitute negligence, making them "responsible" for their problems and removing them from entitlement to sympathy and support. A decline in health following abandonment of a prescribed regimen could lead to charges of stupidity or self-destructive tendencies, whereas a sudden decline in health following adoption of a treatment program could reflect a lack of common sense in choosing the program and/or being the dupe of a physician's desire to push a pet theory. The basic problem confronting people is that there are a variety of unforeseeable consequences that could make their health-related decisions seem unwise in retrospect. A considerable amount of protection from the implications of negative consequences would be gained by seeking and responding positively to others' opinions. Family, friends, and colleagues would be far less likely to point an admonishing finger if they were directly involved in the questionable decisions. Additionally, people could ease

their self-recrimination if they knew that other nonexperts shared their opinions and would have acted similarly.

One final impetus for initiating lay consultation may be the sense of helplessness and passivity imposed by physical impairment and high levels of uncertainty. As discussed by Parsons (1958), a major component of the "illness role" is the relinquishment of personal responsibility. People with physical problems are not generally expected to cure themselves or to choose courses of action independently, but rather are properly passive and malleable objects entrusting themselves to the guardianship of well, strong others. The origins of this concept of "proper" behavior is beyond our focus here, but the illness role does seem to be widely accepted both within and across most cultures. An obvious consequence of this general linkage of dependence with illness is that people who feel or suspect themselves to be ill will be obliged to consult with others before making decisions. For the other reasons reviewed earlier, this consultation will not be limited to or even centered on health care professionals.

Having at least made intelligible the high frequency of initiating lay consultation, let us now turn to the other side of the coin—the fact that nonexperts are virtually always willing to offer medical opinions when consulted and will even do so frequently when not explicitly asked about their feelings. For example, Miller (1973) reports that a woman with a persistent sore throat (which turned out to be symptomatic of neck cancer) was told in strong terms by her family that she was malingering and should ignore the problem because it would certainly fade away. One explanation for this seemingly irresponsible behavior stems from the illness-role concept just discussed. In the same way that people with physical problems feel obliged to consult with others, the consultants themselves may feel it is their duty to provide some basis for action. Failure to offer an opinion would be tantamount to shrugging one's shoulders when told by a child that she cannot find her parents.

The obligation to respond produced by the illness role may be intensified by the highly self-revealing nature of seeking medical opinion. To discuss one's real or potential infirmities is a major act of self-disclosure—of opening oneself up for others' inspection. This form of giving of oneself probably induces a pressure for reciprocity—an implicit demand that the consultant give something in return. It is as if the initiator were saying, "I have revealed something important, made myself vulnerable, and taken a real chance that you won't dangerously mislead me—the least you can do is to get involved in my problem and take a chance in offering some basis for action."

Another force operating on the consultant could be the implicit flattery of being asked for opinions on important matters and the resultant reluctance to forego the status of being "doctor-for-a-day." Health care professionals are almost universally regarded as having the highest occupational prestige, and to be consulted on even a casual basis is to ascend to that level instantly. The role of medical expert is offered to the consultant, and it is a difficult role to refuse. A

desire for this role may also underlie the frequent offering of unsolicited information.

The complexity and ambiguity of medical processes and outcomes may also make it easier for consultants—prompted and tempted by the factors just reviewed—actually to go out on a limb and offer potentially dangerous information. The idea here is that it is usually very difficult to know whether one's medical opinions are helpful or harmful, involving as they do a one-subject sample with no control groups. When someone's health gets worse following action precipitated by a consultant's opinions, who is to say that alternate courses of action would have been any better? If a relapse follows discontinuation of a therapy triggered by a consultant's opinion, how can one know if the relapse wasn't inevitable anyway or if it wouldn't have been even worse had therapy been allowed to proceed? If a friend's suggested home remedy is ineffective, how was he or she to know that you were one of those rare individuals unresponsive to its powers? In many cases, if not most, the consultant can effectively deny responsibility for negative consequences because what constitutes proper and accurate information versus dangerous misinformation is frequently seen as a matter of debate even among professionals (of course, some opinions lend themselves more readily than others to denial of responsibility and therefore should more likely be offered, as is discussed in a later section of this chapter).

Finally, there is some evidence that many people, and perhaps most, have intuitive theories of illness that are fairly systematic and internally consistent. Harwood (1971), for example, described a hot-cold theory espoused by many Puerto Ricans in New York City. Essentially, various symptoms and treatments were seen as either hot (e.g., rashes and penicillin) or cold (e.g., colds and fruit juices), and treatment consisted of prescribing cold-type cures for hot-type problems or vice versa. There are doubtless many other cultural and idiosyncratic medical belief systems, and their existence probably serves to facilitate the offering of opinions greatly. That is, it is not as if the lay consultant has to grab advice out of thin air due to a lack of expertise; rather, the opinions are often dictated by a well-established, readily available, and possibly compelling medical theory. It may also be supposed that people who possess a coherent intuitive theory would be less likely to experience confusion when experiencing a physical difficulty and thus less likely to seek clarification through the lay conferral system.

Implications

Laypersons. Both recipients and providers of lay consultation should realize that there are strong pressures acting on people to offer information with confidence and to be significantly influenced by that information. It is not safe to assume that ignorance of the facts will prevent a consultant from readily offering opinions, nor is it safe to assume that one's opinions will be taken with a large

grain of salt due to obvious lack of expertise. Great care should be taken in the choice of consultants and in the consultant's choice of words.

Health Care Professionals. It is important to realize that patients have a strong need for information. Any tendency to keep them in the dark, for practical or ethical reasons or because of personal discomfort, will probably intensify a preexisting tendency for lay consultation. Concerns with patients' emotional reactions to bad news or feelings that it is pointless or too much effort to inform them of details need to be balanced by the fact that professional silence could well be replaced by the uninformed but influential opinions of family and friends. Care should also be taken to present information in a coherent, systematic fashion, rather than as isolated fragments, in order to compete favorably with the potentially well-developed intuitive theories offered by lay consultants. Furthermore, professionals should try, when feasible, to minimize the costs (reviewed earlier) of seeking and heeding their opinion. Perhaps the easiest ways to cut these costs is to assume an informal and approachable manner, to convince patients that they are unique and important, to avoid stern lectures and recrimination, and to adopt a flexible, bargaining style in giving information, rather than trying to instill a sense of absolute commitment to prescriptions. In brief, the most successful professional consultation may be that which comes closest to simulating the atmosphere of lay consultations.

SOURCES OF VARIATION IN FREQUENCY AND IMPACT

Despite the pressures operating on people to engage in lay consultation, it is still the case that there is significant variation in both its frequency and impact. For example, Suchman (1965) observed that 26% of his sample did not discuss symptoms with nonexpert others and that 22% of those who initiated lay consultation felt the discussion had not provided a clear course of action; Miller (1973) reported that 45% of his sample rejected as invalid the opinions of their lay consultants; and I found that almost 25% of the respondents to my health questionnaire indicated that they never offered medical opinions. The following discussion highlights some of the major sources of individual differences in lay consultation.

Inasmuch as medical discussions with nonexpert others can be seen as a form of social comparison, we can begin with one of the central postulates of comparison theory—the similarity hypothesis. Festinger (1954) proposed that comparison information would be most desired and most influential when it was available from others who were similar to the subject. His reasoning was that dissimilar others may have motives or viewpoints that the subject does not share, and consequently, differences of opinion may signify differences in motives or in

orientation to the issue rather than the possibility that one's feelings are invalid. The similarity hypothesis in essence supposes the subject to say, "How can you know what is right for me if you are not like me?" For example, Democrats would not try to clarify their feelings about a political candidate by comparing opinions with Republicans because their definition of what constitutes a good candidate may be so dissimilar that either agreement or disagreement would be highly ambiguous. As discussed by Goethals and Darley (1977), the emphasis on similar others is particularly strong when one is concerned with deciding on a course of action or with evaluating personal attributes such as capacities and emotions—the most likely topics in lay consultation.

When applied to the clarification of medical issues, the similarity hypothesis suggests that the absence of lay consultants who share the subjects' basic concerns and general outlook will inhibit the desire for and impact of nonexpert information. In two illustrations of this principle, I had subjects play the role of a student with physical problems and then react to comparison information from different types of sources (Sanders, 1980). The first situation assessed the impact of lay opinions on the decision to see a doctor about the appearance of unusual but nondebilitating symptoms. Lay consultation was much more influential if the source was fellow students rather than inner-city housewives. Presumably, this result was due to the fact that other students would be fairly attuned to the meaning of the symptoms for the subject—a student—and to the problems associated with a student's decision to see a doctor. In contrast, the housewives may have had peculiar theories of disease, may have been insensitive to the problems created for a student by the symptoms, or may have used irrelevant criteria for determining when a visit to the doctor was needed.

The second situation involved playing the role of a patient who had just been urged by a physician to enroll in a difficult and painful treatment program. In this case, the opinions of inner-city housewives who had physical problems similar to the subject were much more influential than the opinions of fellow students and friends who were in good health. Here it was the housewives who were most similar to the subject by virtue of their common ailments. Whereas the opinions of healthy fellow students may be based on general principles or unskilled imagination of the subject's circumstances, the afflicted housewives are likely to have more meaningful opinions based on careful consideration of and full exposure to the same uncertainties experienced by the subject.

Another illustration of the importance of similarity between subject and consultant in determining perceptions of health and illness is provided by Fillenbaum (1979). He found that elderly males' perceptions of how well they were could be predicted from the relationship of their actual health (according to professional diagnosis) with that of other elderly males; but these perceptions were unrelated to their standing within more general populations. That is, subjects felt they were in good health if they were doing better than similar others, but they were uninfluenced by the superior or inferior health of dissimilar others. It seems that

they were concerned not with "good health" but with "good health considering that one is an elderly male." In the same manner, my role-playing subjects were concerned not with "appropriate behavior" but with "appropriate behavior considering that one is a student or that one has received this diagnosis." The overall point of this discussion of the similarity hypothesis is that lay consultation will have a frequency and impact proportional to the consultants' ability to place themselves in the subject's position and offer self-relevant information.

A second potential mediator of lay consultation resides in the nature of the medical difficulties themselves. For one thing, some symptoms or treatments or difficulties with professionals, and so on, are more likely to be talked about than others. It is more probable, for instance, that the appearance of blotches on the arm will be brought to the attention of others than will a genital rash; resistance to a doctor's advice will become the subject of lay consultation more often if it is based on the doctor's self-contradictions than if it stems from the physician's facial resemblance to an incompetent uncle; one's degree of success at recovery will be less likely to be a matter of lay discussion for serious cases, when one still looks and feels awful despite improvement, than for mild ills, when it is a less painful topic even without improvement (cf. the discussion of communication with cancer patients by Wortman & Dunkel-Schetter, 1979).

Another consideration is that some problems, due to their exotic nature or complexity, offer little hope of resolution through lay consultation. The consultant may have something to offer for a persistent headache or a recommended liquid diet, but nonexpert information is probably less attractive and compelling in reference to pain produced by blinking or to a recommended chemoradiation treatment. It would seem that many problems would lead subjects to conclude that they have never heard of such a thing and that there is no reason to assume potential consultants to be any better informed. Consultants themselves should also be less willing or able to offer influential opinions when faced with very unusual or involved issues.

One final property of medical problems per se, which may mediate the frequency and impact of lay consultation, is the degree to which these difficulties interfere with normal activities. The discussion of illness roles by Parsons (1958) has as its basis the idea that people will engage in special role-prescribed sickness behaviors when their ability to execute their normal roles (e.g., worker, parent, etc.) is impaired. Because one of these sickness behaviors is to rely passively on others' guidance, I would expect lay consultation to increase in frequency and impact when medical uncertainties are related to the inability to perform normal functions. In another role-playing study, I again had subjects imagine they experienced a particular set of symptoms. A marked increase in their desire for comparison information from fellow students was produced by the addition of a phrase indicating that the symptoms interfered with taking notes in class. The idea of normal role disability may help to explain why: (1) Suchman (1965) found that for a general sample of symptoms, some involving impairment of

normal functions, 74% of the respondents discussed their problems with others, and over 70% were influenced by the information they received; whereas (2) Miller (1973) found that for a sample of head and neck cancer symptoms, none of which involved normal role interference, only 62% engaged in lay consultation, and only 55% of these were influenced by the comparison information. Despite the apparent importance of role interference in mediating information discussions of medical problems, it should be noted that this factor may be culturally specific: Antonovsky (1972) reported high levels of lay consultation independent of role interference in an Israeli sample.

Personal characteristics of both subject and consultant are probably a third major governor of the lay referral system. To begin with, certain personality variables should facilitate the relevant processes. Some people are more habitually self-evaluative than others (cf. Carver & Glass, 1976; Scheier, 1980). These self-evaluative types may be especially likely to be aware of and concerned by unusual symptoms and to clarify their self-evaluations via lay consultation. In contrast, those with little introspective tendency may continue to focus on external problems until the symptoms either disappear or worsen to the point where the need for professional attention is obvious. Mullen and Suls (1980) have obtained evidence suggesting that subjects high in self-awareness are more likely to engage in some form of stress-management tactic than subjects who rarely view themselves as objects of contemplation. This result may be due to the greater awareness possessed by self-evaluators in experiencing internal difficulties and in understanding the need to determine the precise nature of the problem and to embark on some remedial action. If this is the case, self-focused people should be particularly attracted to and influenced by the clarifying and action-facilitating properties of lay consultation.

A second relevant personality variable is the locus of control construct (Rotter, 1966) and, more specifically, the health locus of control orientation (Wallston, Wallston, Kaplan, & Mades, 1976). This variable refers to people's tendency to see self-relevant events such as illness and its treatment as being determined primarily by one's own efforts (internal locus of control) or by environmental forces beyond one's influence such as fate or powerful others (external locus of control). It would seem that people with a strong belief in the role of fate or luck would be unlikely to engage in lay consultation or to offer helpful advice because they would adopt a fatalistic attitude toward the difficulty in question and would assume that deliberate action was irrelevant to the eventual outcome. On the other hand, those who believe that events are determined primarily by one's own actions and/or those of powerful others would want to clarify the problem they were facing so that effective action could be taken; hence, they would be much more likely to seek and heed others' opinions and to offer action-oriented information.

Other individual differences that could directly influence lay consultation are:

1. Self-disclosure (Jourard, 1964). Some people find it easier to discuss intimate personal topics, whereas others feel either too vulnerable or intrusive when such issues are brought up. It is likely that someone who is comfortable in revealing weaknesses will be more likely to initiate and respond to lay consultation than someone who finds self-disclosure unpleasant. Similarly, those who feel at ease in discussing personal problems should be especially likely to listen carefully to others' complaints and confusion, thus drawing out the discussion and instilling an interest in and respect for their opinions.

2. Self-esteem. People with little respect for the validity of their opinions and the wisdom of their actions should be predisposed to initiate and respond to lay consultation; in contrast, those with high self-esteem should be most confident and persuasive in their analyses of others' problems.

3. Extraversion. Gregarious individuals will have developed a larger network of potential consultants than introverts and should feel easier in approaching others about their difficulties due to their greater social experience.

4. Dominance/submissiveness. Some people like to lead; others like to be led. It is clear that submissive types should find it easier to seek and heed others' opinions, whereas dominant types should be more compelling when offering opinions.

5. Trust. Again, it is true almost by definition that the greater one's belief in the capability and goodwill of others, the more likely one is to be a candidate for an influential lay consultation.

A somewhat different category of personal characteristics that probably exerts as much influence on lay consultation as personality variables is the individual's social standing. One prominent element of this category is socioeconomic status (SES). Miller (1973) reported that SES was inversely related to both the frequency and impact of lay consultation. That is, poorer people with less education are particularly likely to seek and respond positively to uninformed medical opinions. This tendency could be partly due to a greater prevalence of intuitive medical theories in lower-class areas, but is probably also the result of the fact that the higher one's SES, the more likely one is to number medical experts among personal acquaintances. Thus, members of the middle and upper classes are more likely to have the option of informal consultation with professionals to counter or obviate the impact of nonexpert information. Furthermore, one of the principal barriers to immediate professional consultation—financial cost—is of course more of a problem for low SES individuals.

Another aspect of social standing orthogonal to SES is one's depth and breadth of social and family interaction. The more people one encounters and/or the more intense one's relationships, the greater the probability that someone will be available who is similar to the subject, at ease with self-disclosures, or in possession of a compelling medical theory—in short, someone who inspires an

influential lay consultation. Although no directly relevant data are available, several findings are consistent with the assumption that being married, having a strong family authority figure, and engaging in frequent superficial and/or in-trust relationships are all factors that increase the frequency and impact of lay consultation (e.g., Cobwin & Pope, 1974; Geertsen, Klauber, Rindflesh, Kane, & Gray, 1975; Hessler, Kubish, Kong-Ming, Ellison, & Taylor, 1971).

Although the preceding discussion of mediators of the lay conferral system's operation is by no means exhaustive, it should suffice to suggest the range of potential facilitating and inhibiting factors. The fact remains, however, that lay consultation is in general very common and influential, despite the numerous ways in which it might be short circuited. Thus, the basic pressures acting on people to participate in the lay conferral system, discussed in the previous section, must be quite strong indeed to be able to overcome so many potential sources of resistance.

Implications

Laypersons. People will often feel incapable of or uncomfortable about discussing medical problems with others due to considerations similar to those just reviewed. An alternative, and potentially dangerous, method of coping is to minimize the significance of the difficulties and try to ignore them. An awareness of the sources of resistance to lay consultation may help overcome them so that one can gain some degree of emotional clarity and initiate meaningful action. For example, it may be realized that a consultant's opinions do not seem helpful because he or she cannot be expected to share the subject's perspective (i.e., the consultant is a dissimilar other). If so, the subject has an idea of who to consult to obtain more useful information rather than continuing to feel that meaningful opinions simply are not available. A second implication of this section is that the urgency with which opinions are sought may not reflect the seriousness of the problem, but may instead be at least partly a function of medically irrelevant aspects of the interpersonal relationship, the nature of the problem, and the personal characteristics of the participants. Similarly, people should be aware that some opinions may seem more cogent than others not because they are more valid but, again, because of medically irrelevant factors such as those just reviewed.

Health Care Professionals. Particular attention should be devoted to providing information to patients who are unlikely to engage in lay consultation, as they would otherwise be trapped with their uncertainties and could become quite difficult to handle. On the other hand, patients who are especially susceptible to lay conferral should be asked about what they have heard so that serious misconceptions can be corrected. If it seems probable that the patient is consulting with particularly influential but nonexpert others (e.g., a similar, high self-esteem,

authoritative family member), it may be advisable to co-opt such others into the medical team so that they can be used to reinforce the professional's viewpoint rather than be left free to subvert it.

POTENTIAL INFLUENCES OF SOCIAL COMPARISON

Thus far, we have been concerned with the general process of obtaining medical information from nonexperts. In the next two sections, attention is focused on the specific content of such information. The *possible* ways in which lay consultation may influence medically relevant behavior is discussed first; the determinants of the *actual* information obtained by social comparison are explored in the following section. In general, influence may be exerted at five different stages of health and illness: (1) behaviors that prevent or induce illness; (2) decisions about the meaning of symptoms; (3) decisions about the treatment of symptoms; (4) responses to professional care; and (5) recovery from illness. Each of these stages can be considered in turn.

1. Behaviors Relevant to the Onset of Illness. Although many medical problems may occur independently of consciously controlled behavior (e.g., congenital diseases), a great variety of difficulties can be forestalled or induced via particular activities. Such activities can range from the Type A workaholic syndrome that has been linked to coronary heart disease (cf. Friedman & Rosenman, 1974), through general exercise and dietetic patterns that can affect overall susceptibility to bodily malfunctions, to specific habits or acts linked to specific problems (e.g., smoking or taking birth control pills). Two forms of social comparison may influence the probability of an individual choosing to engage in or continue these behaviors. The first form is nonverbal and consists simply of comparing the frequency and intensity of one's own behaviors with those of salient others. This comparison will indicate the extent to which each behavior is normative or deviate within the reference sample. In turn, these estimates can encourage the individual to continue with or adopt behavior seen as normative, to abandon behavior seen as deviate, or to establish a sense of individuality by adopting, maintaining, or intensifying deviate behaviors and/or abandoning normative ones. The second form of social comparison influence is verbal, and this consists of individuals' clarifying ambivalent feelings toward a behavior by comparing their reactions with others' opinions. These ambivalences can involve decisions to adopt the behavior (temptations balanced against fears), to intensify the behavior (increased benefits balanced against unknown consequences or increased costs balanced against potential new benefits), or to abandon the behavior (reduced costs balanced against unknown consequences or reduced benefits in opposition to potential new benefits). Influence will be exerted by com-

parison sources adding more credence to one or the other set of conflicting beliefs and feelings through personal adherence to that set. Influence can also be exerted by *creating* ambivalence and setting the stage for behavioral change. This would occur via the expression of beliefs and feelings contrary to those held by the subject but previously not considered by him or her.

2. *Decisions Relevant to the Meaning of Symptoms.* When people become aware of some unusual bodily condition, they are usually interested in determining if this condition is symptomatic of some medical problem. Again, there are two forms of influence that can be exerted through social comparison. In the nonverbal form, one simply observes the frequency with which such bodily conditions (e.g., headache, shortness of breath) appear in others. On the one hand, a high frequency may suggest to the individual that the condition is a common, normal one, and nothing to cause alarm ("everybody gets headaches"). Alternatively, a high frequency may suggest the presence of some potent force to which both oneself and others have been exposed and therefore may favor the conclusion of some medical difficulty ("there's an epidemic"). The verbal form of comparison-based influence stems from discussions of possible antecedents of the condition in question. Attempts at clarification can focus on whether the antecedent was itself a medical problem; for instance, was a headache caused by too much time in the sun (not a medical problem per se) or by a flu virus (a problem in its own right)? Attempts can also focus on whether the antecedent is likely to produce additional symptoms; for instance, is the headache likely to be followed by a sore throat? In either case, the lay consultation is oriented at this stage toward determining if the symptoms can be safely ignored.

3. *Decisions Relevant to the Treatment of Symptoms.* If a person decides that it is not safe to ignore symptoms, the next stage of lay consultation is intended to provide some basis for action. Such action can take three basic forms. In symptom monitoring, the issues involve charting the time course of symptoms and/or being on the lookout for the appearance of additional symptoms. In addition, symptom monitoring may involve establishing criteria for determining whether danger has passed or intensified. Lay consultation can influence expectations about the symptom's time course and about potential new symptoms, and it can help establish criteria for further action as well as encourage the general monitoring approach. The second basic form of action at this stage involves pursuing some form of home remedy. These remedies can take the form of stopping behaviors suspected to have caused the symptoms, initiating behaviors thought to stimulate the appropriate bodily defenses, and/or taking some kind of nonprescription medical agent. Lay consultation can influence both the general and precise forms of home remedy to be adopted as well as support this overall course of action. The third basic action that can be taken if it is felt

that symptoms are medically significant is to seek professional care. Aside from promoting this option, lay consultation can influence decisions involving the general kind of professional most likely to help (e.g., family doctor, emergency room, chiropractor, etc.); the choice of particular individuals on the basis of their interpersonal style, past success with certain symptoms, and so forth; and strategies of self-presentation when consulting professionals (e.g., exaggerate the difficulties so they will be taken seriously vs. act unconcerned so that unnecessary tests will not be hastily administered).

4. *Responses to Professional Care.* A large number of uncertainties can arise from professional care, and the manner in which these are resolved can have strong effects on the success or continuation of the professional/client relationship. The most common issues are probably: (1) the quality of the interaction—how much warmth, courtesy, and interest is the professional exhibiting, and are these levels typical? (2) the competence of the professional—are pet theories, prejudice, or ignorance interfering with the professional's ability to understand and treat the difficulty, and should additional expert opinion be sought? (3) the openness of the professional—is information being kept from the patient, and if so, what are the secrets, why are they being kept, and how can they be brought into the open? (4) the appropriateness of the patient's feelings, attitudes, and behavior—is too much being hoped for, will complaining do any good, should this cure-related side effect be mentioned, and so forth? (5) alternatives to current professional care—are there easier, cheaper, or more effective ways to deal with the difficulty than are currently being pursued, and if so, what are they and how can they be implemented? Furthermore, are there any drawbacks to discontinuing the current approach, and if so, what are they and how can they be avoided? Depending on the specific opinions given, lay consultation can either greatly facilitate or seriously interfere with the effectiveness of professional care.

5. *Recovery.* Social comparison can exert a variety of influences on a patient's recovery from illness, independent of resolving the uncertainties produced by professional care. In its simplest form, lay conferral consists of comparisons between one's own capacities and feelings and those of others who are either in good health or who are afflicted with similar or dissimilar problems (cf. the discussion of typical comparison strategies by Sanders & Kardinal, 1977). Being surrounded by others who are in better health than oneself can lead to subjective exaggeration of one's difficulties, whereas seeing that others are doing worse than oneself can lead to unrealistic optimism about future developments. On the other hand, comparing unfavorably with others could spur determination to improve, and favorable comparisons could lift flagging spirits. Aside from simply observing their relative standing, people can use social comparison with nonexperts to clarify many uncertainties unique to the recovery phase. Typical

problems that can be influenced by lay consultation include: the meaning of unanticipated side effects or of irregular periods of progress, backsliding, and status quo; the appropriate timing of the resumption of normal activity and/or termination of phases of treatment; and the chances of achieving certain results within a given interval. Answers to these problems can seriously affect the speed and completeness of recovery.

Although the preceding review of potential sources of social comparison information is largely speculative and incomplete, it should serve to illustrate the central point of this section. And that point is that lay consultation is not only deep in terms of frequency and impact, but it is also broad in that it can, at least in principle, interact with and possibly affect in crucial ways virtually every aspect of every phase of the journey from health to illness and back again to health.

Implications

Laypersons. Decisions relevant to health care are not only affected by deliberate consultations with others but also by impressions of how often others perform particular behaviors, how many others possess certain bodily conditions, and how healthy others are relative to oneself. In turn, these impressions can influence the attractiveness and probability of health-relevant behavior patterns, the anxiety produced by the appearance of symptoms, and perceptions of and reactions to one's rate of recovery. Awareness that perceptions of health and illness are not strictly a function of one's actual health, nor even of one's conscious attempts to clarify feelings through lay or professional consultation, may help one achieve a more fully rational consideration of appropriate health behavior. It may also help one realize that the experience of illness can create a great amount of uncertainty along a large number of dimensions so that feelings of confusion and the inability to make independent decisions should not be viewed as an indication of personal inadequacy or of being at the mercy of unusually severe and debilitating problems. Those who serve as lay consultants may be impatient, overwhelmed, or flattered by the steady stream of issues they are asked to help resolve, but they should try to keep in mind that this can be a normal part of illness and does not necessarily reflect on either their own strengths or on the information-seeker's weaknesses.

Health Care Professionals. The provision of health care will almost certainly generate at least some uncertainty, and it would be desirable to anticipate the difficulties, bring them out into the open, and resolve them, rather than having them resolved by lay consultants or by having patients endure the stress of confusion. When making recommendations involving the adoption or termination of specific behaviors, some consideration should be given to the frequency of these behaviors in the patient's reference groups as well as to how the patient

would react to performing normative or deviate acts. Attention should also be paid to whether the patient's recovery is being affected by favorable or unfavorable comparisons with the health or progress of others.

DETERMINANTS OF COMPARISON INFORMATION

Unfortunately, there are no relevant data that would enable us to specify the relative probability of each of the influences that have been reviewed. Without knowing how often lay consultants provide particular types of information, it is impossible to determine the overall harm or good produced by the medical opinions of nonexperts. As a first step in making such a determination, this section discusses various pressures acting on consultants to offer or withhold certain kinds of opinions. Some flavor of the total impact of lay consultation should emerge, but obviously this cannot substitute for empirical research into this central issue.

The concept of intuitive theories of illness was discussed earlier (e.g., the hot-cold theory), and these theories are probably a major determinant of the content of nonexpert opinions. Opinions resulting from intuitive systems are also likely to be particularly influential because the subject's problems are treated as exemplars of general and well-established rules, rather than as unique aberrations that require guesswork and trial-and-error solutions. It is therefore important to gain some empirical insight into the prevalence of such intuitive systems, their scope and depth in terms of the range of problems they typically address, and their general tendency to complement or interfere with professional treatment. One speculation can be hazarded at this point, however. The more coherent and comprehensive the theory and the more firmly embedded it is within a culture or community, the less likely it is to interfere seriously with the maintenance or restoration of good health. Such theories must have a considerable grounding in observation and experience and thus could not easily advocate policies with obviously undesirable consequences. If home remedies, for example, were markedly inferior to professional treatment, this difference would eventually be noticed and incorporated into the theory. From this viewpoint, it would appear that people are in greater danger of receiving harmful information when consulting about very unusual problems that cannot be placed in the domain of an established intuitive theory.

A related source of lay opinions is the set of attitudes specified by the Health Belief Model (cf. Becker, 1974). This set includes estimates of the susceptibility of various individuals to various problems, the severity of consequences produced by the problems, and the benefits and drawbacks of specific courses of action. The general effect of these attitudes is to tailor general theories to particular cases. Thus, it might be believed that in general sweating in a cold breeze will

induce a fever, but that Joe or Betty will violate this rule owing to idiosyncratic characteristics, or that heat is a good cure for sore throats, but that Joe or Betty will experience dangerous side effects. These attitudes should serve to reduce the possibility of dangerous lay opinions further if it is assumed that, just as intuitive theories reflect general experience, health belief attitudes will usually be grounded in individual experience. However, as the individual yields a smaller number of observations than a collectivity, the possibility of erroneous conclusions is probably greater for specific health beliefs than for comprehensive general theories.

One final and even more specific source of nonexpert medical opinions is generalization from a single experience. For example, if a certain diet was followed by the disappearance of a stiff back, the same diet might be recommended for a stiff elbow; if a specialist was successful in controlling a migraine headache, a visit to that individual might be recommended for any complaint involving stress; if a broken toe healed without a cast, someone with a broken arm might be dissuaded from following the doctor's recommendation of a cast; and so forth. Because such opinions are based on a single observation and because even slight changes in circumstances can seriously alter the impact of a given behavior, generalization probably represents the most potentially dangerous source of lay medical opinions.

There are a number of factors that may modify the tendency to express opinions solely on the basis of intuitive theories, health beliefs, and generalization. As discussed earlier, lay consultants are somewhat free of responsibility from the consequences of their information owing to the complexity of medical processes and the absence of control groups not exposed to their opinions. However, certain opinions are safer than others. This is particularly true of sentiments that professional advice should be sought or heeded. Even if negative consequences follow from seeing physicians and adhering to their prescriptions, the lay consultant who favored these actions can escape responsibility by placing it on the shoulders of the professionals. In contrast, if a suggested home remedy backfires or if advice to discontinue treatment results in a relapse, it is much more difficult for the consultant to avoid the feeling of contributing to those problems. Thus, rather than a random distribution of the contents of nonexpert information, a bias in favor of placing and maintaining people in the hands of professionals might be expected. Geertsen et al. (1975) found that the presence of a strong family authority figure or a network of close friends, both of which should increase the use and impact of lay consultation, has the effect of increasing an individual's use of professional health care facilities. This observation supports the idea that nonexpert opinions tend to be biased in favor of seeking and heeding professional advice. Similarly, Cobwin and Pope (1974) reported that the number and intensity of one's friendships were both positively related to the incidence of preventive vaccinations and medical and dental checkups. Furthermore, Davis and Eichorn (1963) found that 50% of those who indicated they

were strongly influenced by lay consultation complied with a cardiac recovery regimen, whereas only 34% of those who rejected lay opinions complied with the regimen. Again, it seems that lay consultants tend to channel people into the formal medical system. In two more illustrations of this tendency, Suchman (1965) reported that 54% of the consultants presented with symptoms recommended seeing a doctor, and Apple (1960) found that if a nonexpert felt a person was ill, a doctor visit was urged in 81% of the cases. Interestingly, Apple also noted that professional care was suggested more often if the symptoms were unfamiliar to the lay consultant. Unfamiliar symptoms should reduce the applicability of intuitive theories, health beliefs, and generalization, and therefore should increase the pressure to avoid responsibility by advising doctor visits.

A rather different bias in the content of social comparison information is related to the concept of role interference, discussed earlier. At least in contemporary American culture, there seems to be a tendency to encourage action only when medical difficulties impair the performance of normal functions (i.e., if one cannot operate effectively in social or work roles because of the problem). Apple (1960) found that the tendency of symptoms to interfere with role behavior was the major determinant of whether the symptoms were viewed as constituting medical problems and that role-interference symptoms were 50% more likely to elicit the recommendation of some action from lay consultants. Additionally, Amarasingham (1980) observed that it is commonly believed that medicine should only be taken for as long as one feels sick, with sickness in turn determined largely by role interference. Friedson (1961) also concluded that nonexperts will tend to react to noninterfering complaints as part of one's normal ups and downs and discourage remedial action as well (see also Hartley, 1961, for a developmental perspective on this issue). Although more extensive data are needed, it may be tentatively concluded that lay consultants will tend to resolve medically related uncertainties by minimizing the need for concern or action if the subject is capable of pursuing normal activities. Furthermore, the results of Miller's (1973) study suggests that when action is recommended for noninterfering complaints, lay opinions are much more likely to favor home remedies and monitoring than the aforementioned tendency to channel people into the professional health care system.

Two more influences shaping the content of nonexpert opinions may be tentatively advanced. First, Twaddle (1969) noted that when people are formally, officially under the care of a professional, their reliance on lay consultants is markedly diminished. Similarly, observations by Skipper, Tagliacozzo, and Mauksch (1967) and by Wortman and Dunkel-Schetter (1979) indicate that hospitalized patients feel frustrated in attempts to clarify their situation through discussions with both experts and nonexperts. Although there are probably a number of valid explanations for this reduction, one likely possibility is that lay consultants feel uncomfortable about expressing their true opinions to people whose problems are sufficiently intense to require professional care. This dis-

comfort, in turn, could arise from the ambivalence created by a confrontation with others' serious problems. On the one hand, there is a desire to offer sympathy and encouragement, which may be irrelevant to the patient's current concerns. At the same time, there is a tendency to avoid discussing clearly unpleasant topics, partly out of fear that they will aggravate the patient's condition and partly because they are depressing and upsetting to the consultants themselves. The result of this ambivalence would be a suppression of true feelings, mixed messages of encouragement and aversion to the patient, and/or a total avoidance of illness-related discussion (cf. Wortman & Dunkel-Schetter, 1979). None of these tendencies would provide the patient with very confident or useful opinions. In short, lay consultants may be willing to expound calmly and informatively on what a functioning colleague should do about unusual lumps or what a patient in remission should do to prevent a relapse, but when faced with the emotional concerns of people who are clearly suffering or frightened, half-hearted and ambiguous opinions are more likely to be the bill of fare.

A second and final speculation on the forces shaping nonexperts' opinions arises from a study by Campbell (1975). He found that mothers had a tendency to see symptoms as being more serious if they appeared in their children than if they were manifest in the mothers themselves. Again, there is a variety of plausible explanations for what Campbell termed an "attributional double standard," but one intriguing possibility is that subjects are motivated to suppress the threatening implications of their medical uncertainties, whereas observers/consultants are more likely to respond objectively. For example, unusual lumps may be discounted by a subject who is unconsciously fearful of cancer, whereas a lay consultant would feel remiss in not at least suggesting the possibility of malignancy; the difficulties of breaking off a long relationship and finding a new physician may lead a subject to accept the competence of professional advice, whereas a consultant would be more apt to raise questions; and a subject may try to avoid thinking of the pain involved in a treatment program, whereas the negative overtones likely to surface in a consultant's reactions may force a consideration of this factor. On an overall basis, then, the opinions of lay consultants may be likely to emphasize negative possibilities avoided by the subject because of the threat they pose to the self. Although this proposed tendency of lay consultants to emphasize the threatening aspects of medical uncertainty could have diverse effects, it would almost certainly help clarify the subject's feelings by bringing covert fears into the open where they can at least potentially be resolved.

In summary, the content of nonexperts' opinions is probably determined primarily by idiosyncratic, intuitive medical theories, health beliefs, and generalizations (which are probably least, more, and most potentially misleading, respectively). In addition, general pressures to place and maintain subjects in the professional health care system, to encourage action only when role interference occurs, to offer unsatisfactory information when faced with clearly serious and

unpleasant problems, and to raise threatening possibilities may all interact with these idiosyncratic contents of comparison information in complex and unknown ways. To be sure, much of the discussion in this section has been speculative, and it is best viewed as a guide for empirical research rather than a definitive statement of the issues. However, two implications of this review seem basically sound. First, the number of forces shaping the content of lay opinions, as well as the diversity of these forces, is probably sufficiently large to insure that subjects stand a good chance of being exposed to a range of information reaching from greatly beneficial through innocuous to lethal. Second, the factors that have been reviewed do not point to the lay conferral system as a necessarily inept or undesirable institution but rather allow for the possibility that it does more good than harm. Given the frequency and impact of lay consultation, this is a comforting thought that invites an empirical test. On an even more global level, Hessler et al. (1971) found that a high level of social interaction, which could reflect a large amount of lay consultation, was negatively associated with both physical and psychological disorders. Of course, interpretation of these findings is impaired by the presence of many confounding factors and the use of a correlational design. However, such results encourage follow-up research using longitudinal methods and clear measures of the frequency and content of nonexpert information.

Implications

Laypersons. People should be careful, when giving or receiving comparison information, to avoid placing too much emphasis on the subject's ability or inability to perform normal functions. Although the origins of this role interference bias are open to speculation, it seems clear that there is no necessary relationship between the seriousness of medical problems and the extent to which they inhibit routine behaviors (e.g., the "innocuous" first signs of head and neck cancer). Similar caution should be exercised against the tendency to use generalization as a guide for action because superficially similar cases may differ in subtle but critical ways. Patients in serious or unpleasant conditions may benefit from knowing that their inability to obtain useful comparison information from lay consultants does not necessarily reflect on the poor quality of their relationships or on the hopelessness of their case; rather it is a common problem caused by ambivalent feelings on the part of the consultants. In turn, the consultants themselves would do well to realize that their reluctance to express their true opinions freely comes at a time when patients are most in need of discussion and clarification and that the patient's inability to have a meaningful exchange of opinions can be more stressful than anything the consultants might have to say.

Health Care Professionals. Lay consultation has the potential to reinforce and supplement the professional's concerns and goals beneficially. It would

therefore be wise not to discourage the receipt of lay opinions automatically, but instead to determine the content of such opinions first to see if they are or can be helpful. Second, if it is known that some generalizations are particularly misleading (e.g., if treating a broken arm like a broken toe would be dangerous), special care should be taken to advise clients against such reasoning. Third, the tendency of lay consultants to discourage action if the subject is able to function in normal work and social roles requires special vigilance in administering preventative or recovery programs under these conditions. Finally, patients who are in serious condition and under the professional's direct care may be frustrated in their customary attempts to clarify their condition via lay consultation, so it is especially important for professionals to address and resolve uncertainties in these stages of illness.

IMPLICATIONS OF LAY CONSULTATION FOR HEALTH CARE MODIFICATION

Thus far, we have been exploring the issue of nonexpert medical information as a world unto itself, isolated from other pressures and concerns inherent in health care behavior. In this concluding section, attention is focused on some examples of how lay consultation might affect the success of deliberate attempts to improve people's health through prediction or modification of their behavior.

A good starting point for this discussion is provided by the Health Belief Model (HBM). As was mentioned in the preceding section, the HBM describes an interrelated set of beliefs about an individual's need for professional care together with the costs and benefits associated with such care. This model was formulated in order to facilitate predictions about the likelihood that a person will participate in preventive programs and/or adhere to professionals' suggestions. In turn, good predictive power would allow professionals to concentrate and expand their influence on those targets whose beliefs are likely to interfere with their health. Although the HBM has often successfully predicted relevant behavior, the overall associations are rather weak (correlations of less than .14 are typical), and there have been almost as many complete failures as successes (e.g., Haynes, Taylor, Snow, & Sackett, 1979, Table 5). Furthermore, in most cases of successful "prediction" the correlational methods have left open the possibility that the behavior caused the attitudes, not vice versa. Although there are many possible sources of the HBM's weakness (e.g., the generally unreliable causal link between attitudes and behavior, cf. Wicker, 1969), the influence of lay consultation is a likely contributor. The idea here is that health beliefs may predict relevant behavior, but those beliefs are likely to change as a result of nonexpert comparison information. That is, as the subject progresses through an illness experience, uncertainties may be resolved by lay consultation in such a way that the subject's original health beliefs are altered. Any attempt, then, to

use the HBM as a predictive device should determine that the attitudes used to make the prediction are still held by the subject when the relevant behavior is measured. An illustration of this principle is provided by Taylor's study, described by Becker, Maiman, Kirscht, Haefner, Drachman, and Taylor (1979). He found that when beliefs about the seriousness of hypertension and the safety of combative drugs were measured prior to being diagnosed as hypertensive, these beliefs failed to predict pill-taking compliance. However, the same attitudes were successful predictors if they were measured 6 months after diagnosis. This clearly suggests that the experience of illness results in a modification of health beliefs. Lay consultants, in turn, are a probable source of such modification.

A second approach to controlling health behavior that should be affected by nonexpert information is the attempt to induce rational decisions by providing objective medical information. The highly publicized seven warning signs of cancer represent one such attempt to offer reliable information as a basis for health behavior. To the extent such information is seen as being an objective description (i.e., a true statement of reality), this approach should theoretically eliminate the influence of lay consultation. Festinger's theory of social comparison (1954) proposed that people would not use comparisons with others to clarify their uncertainties if an objective basis for evaluation was available (Hypothesis II and Corollary II B). This position implies that if people were given an objective basis for health care decisions, such as whether to see a doctor or whether to continue treatment, lay consultants would have relatively little input. However, the existence of substantial interference with the persuasive impact of objective information is indicated by the frequently observed failure of this approach to affect compliance with remedial or preventive regimens (e.g., Haynes et al., 1979, Table 5; Schmidt, 1977). That is, given clear and abundant information about the nature of their problems and the costs and benefits of compliance, patients are more likely than not to ignore or discount this objective knowledge. A possible explanation is that, despite Festinger's propositions, lay consultation continues to be influential when contrasted with objective information, and perhaps the former is even more influential than the latter.

As a preliminary exploration of this possibility, I had subjects role-play the development of symptoms and then gave them both objective and social comparison information relevant to the need to see a doctor (Sanders, in press). It was found that if the objective information suggested that a doctor should be consulted, the effect of comparison opinions to the contrary (i.e., not to go) was completely eliminated, as hypothesized by Festinger. On the other hand, if the objective information suggested there was no need for alarm, the effect of contrary comparison opinions (i.e., to see a doctor) remained at full strength. For whatever reasons, subjects were much more willing to believe that an objective test could "prove" that they were ill than that they were healthy, relying in the latter case on the opinions of nonexperts. In general terms, these results suggest

that objective information does not automatically rule out the use and impact of lay consultation. Research into the conditions under which objective information is successful in overriding social comparison information should help to pinpoint areas where health education programs will be most effective.

One final example of the interaction of lay consultation with health modification efforts involves the use of social support groups to ease the burdens of chronic illness and to hasten recovery from acute episodes (cf. Kaplan, Cassel, & Gore, 1977, for background on the social support concept). The basic approach here is to enlist the involvement of family, friends, or other patients in the subject's problems and coping efforts. It is hoped that these support groups can offer numerous benefits to the subject, such as bringing disturbing fears into the open and dispelling or minimizing them, offering sympathy and encouragement, performing chores that are stressful or that interfere with treatment requirements, and serving as calm and effective models that generally set a good example for the subject to follow. Despite all these potential benefits, however, the one extensive attempt to improve health via support groups has yielded rather negative results (Caplan, Robinson, French, Caldwell, & Shinn, 1976). These investigators divided patients receiving hypertension medication into three groups: Control, in which normal therapist/patient relationships were unmodified; Lecture, in which patients attended four 1-hour presentations on the nature of high blood pressure and its treatment; and Social Support, in which the lectures were supplemented by the joint participation of family and friends of each patient and a group-dynamics expert was present to supervise various discussions and role-playing exercises designed to encourage the exchange of socioemotional support. It was found that both the Lecture and Social Support groups surpassed the Control group in both the motivation to adhere to regimens and in the actual adherence, as well as in subjects' satisfaction with efforts being made on their behalf. The surprising result was that the Social Support treatment not only failed to improve upon the gains made by the Lecture treatment, but it was actually somewhat, and on occasion significantly, less effective. For example, subjects felt that others' concern was less helpful, that they received less tangible support, and that their medical information was less adequate if they were in a Social Support group than if they just heard the lectures. Thus, the attempt to involve others actively in the patient's problems only served to disrupt the positive effect of objective information mildly. Several reasons for the failure of social support to be truly supportive are discussed by Wortman and Dunkel-Schetter (1979). All of these reasons basically specify ways in which unwanted and/or disturbing comparison information can be supplied by lay consultants. It seems clear that increasing social support will also increase the frequency and impact of nonexpert opinions. As discussed in an earlier section on the possible influences of such opinions, it is quite possible, though not necessary, for these opinions to counter or even reverse the beneficial aspects of social support. Therefore, it is important to determine what kind of comparison information is likely to result

from the introduction of social support. For example, in the particular situation studied by Caplan et al. (1976), hypertension did not significantly interfere with normal functions. As discussed earlier, lay consultants are biased in the direction of recommending inaction in the absence of role interference. Thus, most patients may have been told by their social support groups that preventive efforts were not necessary, resulting in the failure of social support to improve adherence despite the groups' potential benefits.

These three examples should suffice to illustrate the general point that the operation of the lay conferral system can often interact with and impair the effectiveness of attempts to predict or modify health behavior. As further research clarifies the frequency, impact, and content of comparison information in various situations, it should be possible to design health care programs that either neutralize the influence of lay consultation or that use its influence to their own advantage.

SUMMARY

It is very common for people to seek and heed the opinions of nonexperts in clarifying uncertainties and taking actions relevant to health and illness. Although it is surprising that uninformed medical advice would be sought or offered, this practice has a solid basis in people's experiences, attitudes, and goals. Despite the overall frequency and impact of lay consultation, numerous sources of variation in its magnitude can be identified. The lay conferral system is likewise variable in terms of the types of influence it can exert as the subject moves from health to illness and back again to health. General sources of the content of nonexpert opinions can be specified, together with certain biases that help shape these opinions, but little is known about the relative or absolute frequency of specific types of information. Nonetheless, it seems clear that lay opinions *can* be beneficial despite their lack of expertise, and this may be the case more often than not. Finally, it is important for designers of health care modification programs to anticipate how lay consultation will interact with their efforts and, when possible, to incorporate it into their procedures.

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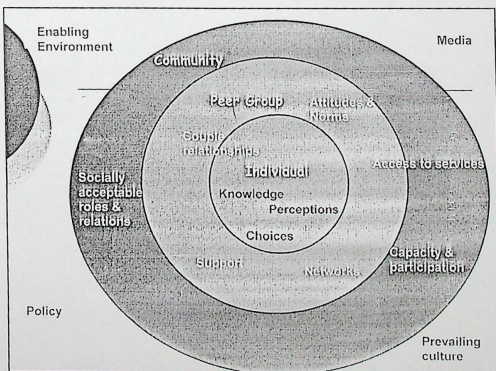
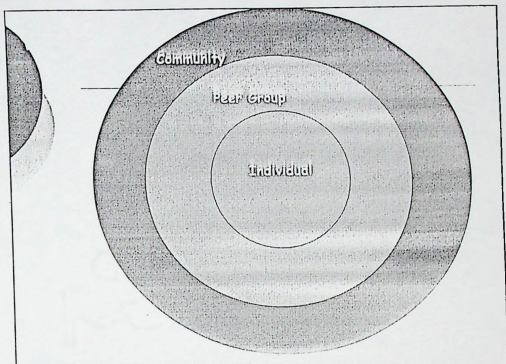
What determines behaviour: back to theory


Martine Collumbien



Objectives

- Understand multiple levels of influence on behaviour
- Learn more on individual, interpersonal and community level theories of behaviour change
- Understand some key concepts/constructs and their practical application in health interventions






Ecological perspective

Change people individual

*reciprocal causation
between individuals interpersonal
and their environments*

Change environment community



Individual-oriented theories / models

Stages of change

Individual's
readiness to
change towards
more healthy
behaviour

focus

Health belief model

Persons' perception
of the threat of a
health problem and
the appraisal of
recommended
behaviour to
prevent or manage
problem

Key concepts in stages of change

Key Concept	Definition
Pre-contemplation	unaware of the problem, has not thought about change
Contemplation	thinking about change
Decision/ Determination	making a plan to change - preparing
Action	implement a specific action plan
Maintenance	continue desired actions, repeating recommended steps

Application of key concepts in stages of change

Key Concept	Application
Pre-contemplation	Increase awareness of need for change, personalise information on risks and benefits
Contemplation	motivate and encourage to make specific plans
Decision/ Determination	assist in developing concrete action plans, setting appropriate goals
Action	assist with feedback, problem solving, social support, reinforcement
Maintenance	assist in coping, reminders, finding alternatives, avoiding relapses

Key concepts in health belief model

readiness
to act

Key Concept	Definition
perceived susceptibility	chances of getting a condition (eg. STI)
perceived severity	opinion of how serious an STI and its sequelae are
perceived benefits	opinion on how effective condoms are to reduce risk getting STI
perceived barriers	opinion of psychological/tangible cost of using condom
cues to action	strategies to activate 'readiness'
self-efficacy	confidence in one's ability to act

Application of key concepts in HBM

Key Concept	Application of concepts
perceived susceptibility	personalise risk based on person's features/ behaviour, heighten suscept...
perceived severity	specify consequences of risk and the condition
perceived benefits	define action to take: how, where, when - clarify positive effects
perceived barriers	identify and reduce through reassurance, incentives, assistance
cues to action	provide how to information, promote awareness, reminders
self-efficacy	provide training in performing action

Interpersonal level: Social Learning Theory (social cognitive theory)

focus

human behaviour is explained in terms of a three-way, dynamic, reciprocal theory in which personal factors, environmental influences and behaviour continually interact

addresses

- psychosocial factors that influence behaviour
- strategies to promote behaviour change

Key concepts in social learning theory

Key Concept	Definition
Reciprocal determinism	change is bidirectional - results from interaction
Behavioural capability	knowledge and skill to influence behaviour
Expectations	beliefs about likely results of action
Self-efficacy	confidence in ability to take and persist in action
Observational learning	beliefs based on observing other like self and/or visible results
Reinforcement	responses to a person's behaviour that increase or increase chance of recurrence

Applications of key concepts in SLT

Key Concept	Applications
Reciprocal determinism	involve individual and relevant others; work to change the environment
Behavioural capability	provide information and training about action (what to and how to do it)
Expectations	incorporate information about results of action
Self-efficacy	point out strengths; approach change in small steps; use persuasion and encouragement
Observational learning	beliefs based on observing other like self and/or visible results
Reinforcement	responses to a person's behaviour that increase or increase chance of recurrence

Community level theories

- o Community mobilisation theories
emphasizes active participation and development of communities that can better evaluate and solve health and social problems
- o Organisational change theories
concerns processes and strategies for increasing the chances that healthy policies and programmes will be adopted and maintained in formal organisations
- o Diffusion of innovations theory
addresses how new ideas, products and social practices spread within a society or from one society to another

but examples

focus

Key concepts in community organisation

Key Concept	Definition
Empowerment	process of gaining mastery and power over oneself/ one's community, to produce change
Community competence	community's ability to engage in effective problem solving
Participation and relevance	learners should be active participants and work "start where the people are"
Issue selection	identifying winnable, simple, specific concerns as focus for action
Critical consciousness	developing understanding of root causes of problems

Applications of key concepts in community organisation

Key Concept	Application
Empowerment	give individuals and communities tools and responsibility for making decisions that affect them
Community competence	work with community to identify problems; create consensus and reach goals
Participation and relevance	help community set goals within the context of pre-existing goals and encourage active participation
Issue selection	assist community in examining how they can communicate the concerns, and whether success is likely
Critical consciousness	guide consideration of health concerns in broad perspective of social problems

Key concepts in organisational change

Key Concept	Definition
Problem definition (awareness stage)	problems recognised and analysed; solutions sought and evaluated
Initiation of action (adoption stage)	policy and directive formulated; resources for beginning change allocated
Implementation of change	innovation is implemented, reactions occur, role changes occur
Institutionalisation of change	policy or programme becomes entrenched in the organisation; new goals and values are internalised

Application of key concepts in organisational change

Key Concept	Application
Problem definition (awareness stage)	involve management and other personnel in awareness-raising activities
Initiation of action (adoption stage)	provide process consultation to inform decision makers and implementers of what adoption involves
Implementation of change	provide training, technical assistance and problem-solving aid
Institutionalisation of change	identify high-level champion, work to overcome obstacles to institutionalisation and create structures for integration

Key concepts in Diffusion of Innovations


Characteristics of innovations can improve the chances they will get adopted and diffused

Key Concept	Definition
Relative advantage	degree to which innovation is better (more convenient, prestigious, satisfying) than the practice it replaces
Compatibility	how consistent is innovation with values, past experiences and needs of the potential adopters
Complexity	how difficult is innovation to understand or use
Triability	extent to which the innovation can be experimented with before a commitment to adopt is required
Observability	extent to which innovation provides tangible and visible results

Application of key concepts in Diffusion of Innovations


Key Concept	Application
Relative advantage	point out unique benefits: convenience, time saving, prestige
Compatibility	tailor innovation for the intended audience's values, norms and situations
Complexity	create idea/product to be uncomplicated. easy to use and understand
Triability	provide opportunities to try: free samples, money back guarantee
Observability	assure visibility of result: feedback or publicity

Communication channel: two-step flow of communications in which opinion leaders mediate the impact of the mass-media and emphasize value of social networks and interpersonal channels for adoption decision




How to use theory and constructs

- o Look at the focus of what the theory addresses
- o Choose determinants/constructs/ key concepts that are relevant to your context
- o Look at the practical application for influencing that determinant through your intervention strategies



How to use theory and constructs

- o Do not limit yourself to one theory!
- o Pick and choose according to your BDI model and your constraints
- o Your NGO may not be able to change all the concepts/ determinants in one theory, and not all constructs are going to be equally relevant
- o Strategists at state level – see that all important barriers to behaviour change are identified and addressed by coordinating different interventions



Recap on how and why to use theories

- Theories as focal points for needs assessment and problem diagnoses and to identify points of intervention at different levels
- Theories as reference to design intervention strategies and messages
- They identify the assumptions behind intervention strategies and pinpoint intermediate steps to be assessed in evaluation
- We cannot substitute theory for planning and research



All for Equity

World Conference on Social Determinants of Health

RIO DE JANEIRO | BRAZIL | 19-21 OCTOBER 2011

World Health
Organization

Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.
2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.
3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.
4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.
5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 ("Reducing health inequities through action on the social determinants of health"), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.

6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. *To adopt better governance for health and development*

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;

11.2 We pledge to:



- (i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;
- (ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;
- (iii) Support comprehensive programmes of research and surveys to inform policy and action;
- (iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;
- (v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;
- (vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;
- (vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;
- (viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;
- (ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;
- (x) Promote and strengthen universal access to social services and social protection floors;
- (xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;
- (xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. *To promote participation in policy-making and implementation*

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:



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World Health
Organization

- (i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;
- (ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;
- (iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;
- (iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;
- (v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;
- (vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;
- (vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. *To further reorient the health sector towards reducing health inequities*

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

- (i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;
- (ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;
- (iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;
- (iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;
- (v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;
- (vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;



- (vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;
- (viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;
- (ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. *To strengthen global governance and collaboration*

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

- (i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, *inter alia*, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;
- (ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;
- (iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;
- (iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;
- (v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;
- (vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;
- (vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;



- (viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies' support, particularly the World Health Organization;
- (ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. *To monitor progress and increase accountability*

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

- (i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;
- (ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;
- (iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;
- (iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;
- (v) Improve access to the results of monitoring and research for all sectors in society;
- (vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;
- (vii) Use intersectoral mechanisms such as a Health in All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;
- (viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;
- (ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health;
- (x) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;
- (xi) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social

determinants of health, particularly through the exchange of good practices in this field;

- (xii) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. *Call for global action*

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.





COPASAH Building Theory From Practice

PH-18.

Knowledge building from grounded practice is one of the strategic goals of COPASAH to counter the hegemony of experts and tool based accountability perspective dominating the accountability domain. The COPASAH members have a wide range of resources and examples of citizen centric monitoring in the field of Health Rights. The experiences of practice and different strategies in community based monitoring have been shared through COPASAH's different knowledge products, which include issue papers, cases studies, newsletter and a host of audio-visual products.

Issue Paper 1

Who are we to Care? Exploring the Relationship between Participation, Knowledge and Power in Health Systems

Barbara Kaim, Zimbabwe

In many developing countries like Zimbabwe, health systems fail to meet the needs of the majority, especially of people and communities with less power. Equipped with knowledge and skills to monitor health system practices and with awareness of health rights, communities get enabled to assert their political power. With collective action, they are able to address some of those failures. This issue paper focusing on health systems in Zimbabwe, explores how the interaction between people's participation, knowledge and power affects the functioning of health systems in favour of the people. There is a blend of discussions on concepts and issues with descriptions of experiences and case studies from around the globe. It attempts to discuss alternatives and approaches that can be used to build a more just and equitable health system.

<http://www.copasah.net/who-are-we-to-care-participation-knowledge-and-power-in-health-systems--tarsc-zimbabwe.html>

Issue Paper 2

How do we know we are making a Difference? Challenges before the Practitioner of Community Monitoring Processes in Assessing Progress and Evaluating Impacts

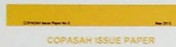
Abhijit Das, India

Community based monitoring has emerged as a promising practice for improving programme effectiveness, and as a key component of rights-based implementation of health programmes in India and other parts of the globe. It has proved to be significant in 'empowering' communities and in building their capacities in engaging with service providers, to negotiate better services for themselves. Using practical examples drawn from the author's own practice and two examples of field level practice in India, this paper discusses the different conceptual dimensions of community monitoring and explores the difficulties of monitoring and assessing progress and results. It also explores a set of mechanisms for documenting and assessing progress drawing upon contemporary practice of evaluation. The authors propose a practical methodology for assessing progress, drawing lessons and for establishing robust evidence based results in the field of community based monitoring.

http://www.copasah.net/uploads/1/2/6/4/12642634/issue_paper_how_do_we_know_we_are_making_a_difference_copasah.pdf



For CLIC
TW



Ethical Issues in Community Based Monitoring of Health Programmes: Reflections from India

Renu Khanna, India

When community based monitoring of health systems are developed for advocacy and social accountability mechanisms, sets of power relationships and ethical dilemmas often arise. The issue paper from India reflects upon existing power discourses in the process of community based monitoring and planning. It draws upon modern bioethics (in community action and otherwise) and specifically shows how community based monitoring and planning, whilst maintaining uniqueness, intersects with several other realms including: community development and social action, community based research, public health interventions and social science research. The issue paper examines various sets of relationships within the process of community based monitoring and planning, and the associated power dynamics and ethical issues emerging in each set of relationships.

<http://www.copasah.net/ethical-issues-in-cbm-of-health-programmes--sahaj-india.html>



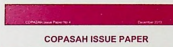
Issue Paper 4

Developing an Approach towards Social Accountability of Private Healthcare Services

Anant Phadke, Abhijit More, Abhay Shukla, Arun Gadre, India

The Private Health sector forms a major component of the health care systems in developing countries like India. In India, this sector is large, varied and unregulated, and is riddled with several problems including substantial irrationalities in care provision, lack of protection of patient's rights, lack of social accountability, lack of grievance redressal mechanisms and so on. This paper discusses the need for social accountability mechanisms in the context of current failure of self-regulation by medical professionals, and weaknesses of existing state regulation mechanisms, leading to a perceived accountability deficit in private healthcare services. It proposes likely steps and processes by which social accountability of private healthcare services could be developed in India, while drawing on some efforts made towards this in developing countries and lessons learnt from them.

<http://www.copasah.net/developing-an-approach-towards-social-accountability-of-private-healthcare-services---sathi-india.html>



CASE STUDIES

Women in the Lead: Monitoring Health Services in Bangladesh

Sarita Barpanda, Samia Afrin, Abhijit Das

There is a strong interlinkage between accountability and movement building, and this was recognised by Naripokkho, a national organisation working for reproductive and health rights and rights of women in Bangladesh. Naripokkho initiated movement and activism with marginalised women in Bangladesh based on questions around service accountability or political accountability, that could prevent the needless deaths of women and provide better health services. The case study Women in the Lead: Monitoring Health Services in Bangladesh discusses the activities, outcomes and challenges faced in implementing the three pronged accountability approach of organising women from marginalised sections into Nari Dal (groups of marginalised women at village level) training them to conduct monitoring visits in hospitals and working with elected representatives to create a participatory and relevant review and planning mechanism.

http://www.copasah.net/uploads/1/2/6/4/12642634/women_in_the_lead_monitoring_health_services_in_bangladeh_-_sarita_barpanda_samia_afrin_abhijit_das.pdf

Case Study 2

Accountability and Social Action in Health - A Case Study on Solid Waste Management in Three Local Authority Areas of Zimbabwe

Training and Research Support Centre (TARSC) with Civic Forum on Housing (CFH)

Solid waste management has been a major public health challenge to most urban local authorities in Zimbabwe. Rapid urbanisation in the past decade coupled with economic decline and social disruption has placed considerable strain on local authority resources, resulting in their failure to provide adequate services to residents. To build capacity, strengthen accountability and facilitate sustainable options at the local level on solid waste management, Training and Research Support Centre (TARSC) and Civic Forum on Housing (CFH) in Zimbabwe used participatory research to map the situation. The community-based researchers implemented civic education on social waste management and clean-up campaigns. As civil society, the researchers also engaged with local authorities and the private sector on waste recycling and reuse, monitored and raised issues with the local authority on waste disposal and used community feedback meetings to raise awareness and provide feedback and review of actions. This case study on Accountability and Social Action in Health – in three local authority areas of Zimbabwe shares the evidence and experience of the research, activities and the lessons learnt by TARSC and CFH. It also maps the feedback and review activities undertaken with communities, the private sector and service organisations in three local authority areas of Zimbabwe and the lessons learnt by TARSC and CFH.

http://www.copasah.net/uploads/1/2/6/4/12642634/accountability_and_social_action_in_health_zimbabwe.pdf

Case Study 3

Claiming Entitlements: The Story of Women Leaders' Struggle for the Right to Health in Uttar Pradesh, India

Abhijit Das and Jashodhara Dasgupta

The situation of maternal health particularly in the state of Uttar Pradesh (India) is distressing. In addition to a poorly equipped and weak health system, there are reports of corruption across the system and women's experiences as well as small scale studies indicate that women face abusive and disrespectful behaviour from both nurses and doctors. The adverse experiences of women as they came to hospitals for their delivery, energised Community Based Organisations (CBOs) from different districts across the state of Uttar Pradesh to come together to deal with the situation. These CBOs along with SAHAYOG, a state-level resource organisation, implemented a state-wide campaign, which led to the formation of the Mahila Swasthya Adhikar Manch (MSAM). This case study Claiming Entitlements: The Story of Women Leaders' Struggle for the Right to Health in Uttar Pradesh, India recounts how a group of women from the extremely marginalised sections of society have become empowered and are monitoring their entitlements around health services and other services associated with the social determinants of health. It describes the evolution of the Mahila Swasthya Adhikar Manch (Women's Health Rights Forum), its activities and some of the results of their advocacy action with a focus on their empowerment process.

http://www.copasah.net/uploads/1/2/6/4/12642634/claiming_entitlements.pdf

Community Based Monitoring and Planning in Maharashtra, India

Abhay Shukla, Shelley Saha, Nitiin Jadhav

The National Rural Health Mission (NRHM) launched in 2005 in India articulated provisioning of universal access to equitable, affordable and quality healthcare, especially for people residing in rural areas, women, children and poor. With a view to increase people's participation for improving health governance and strengthen the community interface with the public health service system NRHM outlined Community Based Monitoring of health services as an effective strategy. The case study: Community Based Monitoring and Planning in Maharashtra, analyses the diverse experiences of community action for accountability of health services that have emerged in the state of Maharashtra in India, after the NRHM came into being. The focus is on drawing out lessons from organising several hundred Jan Sunwais (Public hearings) and dozens of 'stories of change' associated with this process. The strategies discussed will be of value for health and social activists working for accountability of public services in various contexts across the world.

http://www.copasah.net/uploads/1/2/6/4/12642634/community_based_monitoring_and_planning_in_maharashtra.pdf

Case Study 5

Citizen Monitoring to Promote the Right to Health Care and Accountability

Ariel Frisancho and Maria Luisa Vasquez, Peru

In countries like Peru which is mired with inequality and poverty, health care equality cannot be achieved only with technical interventions and increased resources allocated to health care. Transparency and accountability in health system remain a challenge and significant and sustainable changes can be achieved if citizens are involved in the design and adjustment of social policies and the programs that implement them, thus ensuring that their needs have been properly considered and addressed. Citizen monitoring in health care promotes transparency and accountability which are essential for good governance and democracy. The case-study: Citizen Monitoring to Promote the Right to Health Care and Accountability from Peru is a demonstration of citizen engagement in building transparency and accountable systems, which are essential for good governance and democracy. It focuses on the key importance of strategic alliances with public and civil society actors to strengthen the capacity of rural women's agency and to address unequal power relations. The case study highlights how principles of the International Human Rights framework have been used at the local level in an effort to strengthen the quality of care provided in health care services. This study exemplifies the accountability approach based on dialogue and the promotion of good governance
http://www.copasah.net/uploads/1/2/6/4/12642634/citizen_monitoring_to_promote_the_right_to_health_care_and_accountability_-_care.pdf

Community of Practitioners on Accountability and Social Action in Health

VISION

Communities are actively engaged in promoting accountability and transforming health systems towards the realization of social justice.

MISSION

Our mission is to nurture, strengthen and promote collective knowledge, skills and capacity of community-oriented organisations and health activists - primarily from Africa, Asia and Latin America - working in the field of accountability and social action in health, for promoting active citizenship to make health systems responsive, equitable and people-centred.

Shared Practice



COPASAH



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www.copasah.wordpress.com

Grounded Knowledge



COPASAH



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For further information and suggestions contact:

GLOBAL SECRETARIAT & COMMUNICATION HUB

Centre for Health and Social Justice

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WHAT IS COPASAH?

A global network of
community of practitioners
(from global south) sharing a
community- centric vision and
human rights based approach
to health, health care and
human dignity

We are connected.
we share and learn from
each other



CENTRAL EUROPE
LATIN AMERICA
SOUTH ASIA
EAST SOUTHERN
AFRICA



COPASAH



Community
of
Practitioners
on
Accountability
and
Social Action
in
Health

**SHARED PRACTICE.
GROUNDED KNOWLEDGE.**

www.copasah.net
copasahnet@gmail.com

Sexual & Reproductive Rights Lawfare: Global Battles

About the Project

Today, we see a growing judicialization of sexual and reproductive rights around the world – including rights related to abortion, gender identity and sexual orientation. At the domestic and international level, courts have emerged as central arenas in political-moral battles to further - and limit – these rights. In this context, the **Centre on Law & Social Transformation** (LawTransform) in Bergen, Norway is coordinating a multi-country research project titled, “**Sexual & Reproductive Rights Lawfare: Global Battles**” with researchers from all around the world, including India. The work in India will be done in collaboration with the **Centre for Law and Policy Research (CLPR)** in Bengaluru. The project aims to understand the nature, causes and, particularly, the consequences of sexual and reproductive rights *lawfare*, which we define as strategies adopted by civil society actors that engage rights, law and legal institutions in order to achieve policy reform and social change. CLPR will undertake semi-structured interviews with select Indian organisations working in the area of sexual and reproductive rights.

About Centre on Law and Social Transformation

LawTransform was established in 2014 with the aim to bring together scholars, students and practitioners who share an interest in how law shapes societies, and the use of rights and courts as tools for social change. Fellows and affiliates come from numerous institutions in Norway and globally, and are drawn from a broad range of academic fields, including law, political science, economics, sociology, anthropology, philosophy, medicine and psychology. Through a number of interdisciplinary research projects, LawTransform explores how law and legal institutions function, and how legal strategies are used as political tools (*lawfare*) to advance goals such as children’s- and migrants’ rights, health, sustainable development, peace and gender equality – and develop new methods to study the effects. For more information see www.lawtransform.no.

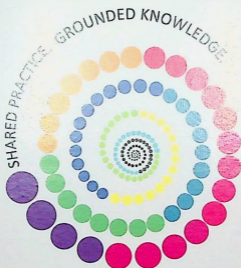
About Centre for Law and Policy Research

The Centre for Law and Policy Research, Bangalore is a not-for profit research organisation committed to research, litigation and advocacy in the public interest. Over the years, diverse and experience-driven strategies have enriched the meaning and scope of public interest lawyering in India. CLPR believes that promoting and relying on data driven, social science research and analysis which influences and shapes constructive solutions to the myriad public policy challenges in India is of paramount importance towards meaningful engagements with courts and the justice system. For more information see <http://clpr.org.in>.



COPASAH

Community of Practitioners on
Accountability and Social Action in Health



A Global Network of
Community Practitioners
in Social Accountability (Health)
sharing a community- centric vision and
human rights based approach to health,
health care and dignity



www.copasah.net

Yes, I am interested to be connected with COPASAH

Name: _____

Organisation/Institution: _____

Country: _____

Email: _____

Watch out for...

COPASAH Global Symposium on
**CITIZENSHIP, PARTICIPATION, GOVERNANCE
AND ACCOUNTABILITY IN HEALTH**

Join Us in New Delhi (India) in February/March, 2019

THEMATIC HUBS

COPASAH strives for field building through three **Thematic Hubs** that concern Citizens' Right to Health:

Reproductive, Maternal Health and Access

Indigenous Peoples' Rights and Accountability

Accountability of Private Medical Sector

Get Involved in the Thematic Hubs for Consultations,
Capacity Building of Practitioners, Creating Knowledge
and Advocacy for Social Accountability

Know more: <http://www.copasah.net/thematic-hubs.html>

COPASAH SOCIAL ACCOUNTABILITY DIALOGUES (CoPSADs)

COPASAH holds a series of CoPSADs to foster sharing and mutual learning on social accountability practices through the innovative use of communication technologies.

Participate in the CoPSADs

Know more:

<http://www.copasah.net/socialaccountability-dialogue.html>

Be Connected

Email: copasahnet@gmail.com



COPASAH

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www.copasah.net

COPASAH Global Symposium 2019
On
Citizenship, Governance and Accountability in Health

*Role of the Community in Strengthening Accountability of Health Systems for Achieving
Universal Health Care/ Sustainable Development Goals*

**BUILDING A PRACTICE BASED SOUTHERN COUNTER NARRATIVE ON TRANSPARENCY,
ACCOUNTABILITY AND PARTICIPATION**

Context -The Alma Ata Declaration of Health for All by 2000 in 1978 marked a new shared aspiration for all citizens of the earth. It elevated health to the realm of a fundamental human right and comprehensive primary health care was seen as an achievable goal. Community participation was centre-staged as one of the core principles. In the last four decades, the goal of Alma Ata has not been met and the vision of comprehensive primary health care for all has been corrupted by increasing privatization and high costs of care as well as techno-centric fragmentation of care leading to high levels of inequality in health outcomes. There have been some efforts to ensure a level of continuity in the discourses around health care for the poor through focus on approaches like Universal Health Coverage, Universal Access to Health Care, Social Determinants of Health, Millennium Development Goals as well as the current efforts on the Sustainable Development Goals (SDGs). In some ways the SDGs because of their universal and interconnected nature and emphasis on leaving no one behind allows an opportunity to review the functioning of health systems to strengthen participation, equity and accountability.

The current Director General of WHO, Dr. Tedros Adhanom Ghebreyesus, has emphasised on Universal Health Coverage as a human right in light of the SDG Goal 3.8 which calls for achieving the following target by 2030: *achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all*. He also emphasised that ‘a strong primary health care platform with integrated community engagement within the health system is the backbone of universal health coverage’.

COPASAH (Community of Practitioners for Accountability and Social Action in health) was started in 2012 by a group of practitioners, who had been using Social Accountability approaches to strengthen the linkage between communities and the health system to provide quality, accountable care. It is essentially a learning network with a focus on marginalized communities where practitioners learn from each other and by distilling lessons from practice and a bottom up process. Today COPASAH community consists of over 300 organisations and individual members and around 730 listserv members across different regions of the world and COPASAH is working closely with many academics sharing lessons on how to improve elements of participation and increase equity and accountability of health systems. COPASAH members have also been specifically exploring equity and accountability in the context of private health care as well as for indigenous and other excluded communities.

Building upon the current interest on achieving universal health coverage and the need to include the most marginalized within the ambit of health systems as an active participant, COPASAH proposes to organize a Global Symposium on Citizenship, Governance and Accountability in Health.

The theme of the Symposium will be *Role of the Community in Strengthening Accountability of Health Systems for Achieving Universal Health Care*. The overall purpose of the Symposium will be to provide a platform for learning, exchange and knowledge building on the issues related to theme by grassroots practitioners, programme managers, thematic experts, academics as well as donors and international agencies. A unique element of the Symposium will be its focus on community level practice and bottom up knowledge building processes.

Objectives and Outcomes – The overall objectives of the COPASAH Global Symposium are:

1. Showcase the ‘state of the field’ by providing practitioners to share their experiences of working on issues related to participation, social accountability, citizenship and governance; and facilitate peer to peer learning.
2. Provide opportunities for interactions between academicians, researchers, development organisations, donors and practitioners to discuss and debate issues of common concern and distill lessons on how participatory and social accountability practices could strengthen health systems and reduce inequities in health outcomes towards achievement of desired outcomes SDGs, UHC and Health for All.
3. Synthesise bottom up grounded knowledge from the discussion among participants from different stakeholder groups and share the same widely.

The Key Outcomes that are envisaged are:

1. Synthesis of new learning from discussions between practitioners, managers, researchers and other stakeholders around participation, accountability and health equity. These lessons are potentially very important for achievement of SDGs related to health.
2. Sharpening of practitioner skills and development of new tools through mutual sharing and learning
3. Networking and relationship building between practitioners of different regions and between practitioners and other stakeholders like programme managers, researchers etc.
4. Developing written as well as audio-visual learning resources for the field through documentation of all key sessions and their subsequent synthesis
5. Establish the importance of participation, social accountability and bottom up learning for securing health equity and strengthening health systems to achieve Universal Health Care and the SDGs and the role of COPASAH and a resource network for the same.

Themes and Structure – The overall contents of the Symposium will cover a set of broad themes. These will include

- Community Participation in Governance and Accountability for Health systems strengthening

- Leaving No One Behind –Improving access to quality health services for Indigenous Communities and other marginalized Ethnic Groups
- Revisiting Reproductive Health - Completing the unfinished agenda of securing reproductive health and rights for all.
- Setting the framework and agenda for demanding accountability of the private medical and health care sector
- Forging Alliances between the Community and the Health Workforce

The overall structure of the Symposium will be such that it allow for sharing and interaction between participants on common issues of concern. At the same time there will be opportunities to learn from the experiences of key practitioners and thinkers in the field. In order to keep a focus on practice and practitioners the Symposium will facilitate conversations between delegates by providing formal and translation services in more than one language. The format of the Symposium will be such that there are a minimum of speeches or one way communication. Some of the formats that will be used to stimulate interactions will be as follows:

1. Expert's conversation with a Host with audience participation
2. Film show/ AV demonstration followed by discussions
3. Facilitated Round Table discussions
4. Curated Poster presentation - Gallery walk with discussion
- 5: Skills exchange workshops
6. Cultural engagements

Some of the sessions will be organizer designed in that the participants and the format will be designed by the organisers. Other sessions will be participant designed in which abstracts or presentation ideas will be sought from applicants who wish to attend the Symposium. These abstracts may be submitted as videos or visual presentation of ones work, with focus on the key lesson or experience that the participant would like to share.

Besides these formal sessions there will be spaces and opportunities for informal conversation between participants/delegates. There will also be an exhibition space where participating organisations can showcase their work and approaches to the delegates.

On the day of the Opening Session, which is going to be held in the evening, there will be opportunity for participating organisations to organize self-organised satellite sessions during the day for which space will be provided at the venue by the organisers for a small fee to cover the costs.

PARTICIPANTS – The symposium is expected to bring together 400 delegates which includes at least 200 community based practitioners working on health equity and social accountability and an equal number of participants from human rights/accountability organisations, researchers/ academics working on accountability, health systems and health equity as well as those working on health related public policy, media as well as donor organisations. The participants will be from different regions where COPASAH has its membership eg. South Asia, Western, Eastern

and Southern Africa, Eastern Europe and Latin America as well as other regions like East and South East Asia. We expect a number of researcher and research centres based in Universities in the Global North as well as other Global Organisations working on participation, transparency and accountability to join us. Among the 400 participants we expect to provide travel support to the practitioners from the Global South.

Participation in the Global Symposium will be either through invitation or application. Key practitioners and experts will be invited to participate in the Symposium and invited to contribute to specific sessions. Participants who wish to participate will apply with the specifics of their interest and contribution through the conference website. The organisers will review the application and invite the delegate. Travel support will be provided at the discretion of the organisers.