Empowerment to reduce health disparities

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This article articulates the theoretical construct of empowerment and its importance for health-enhancing strategies to reduce health disparities. Powerlessness is explored as a risk factor in the context of social determinants, such as poverty, discrimination, workplace hazards, and income inequities. Empowerment is presented and compared with social capital and community capacity as strategies to strengthen social protective factors. A case study of a youth empowerment and policy project in New Mexico illustrates the usefulness of empowerment strategies in both targeting social determinants, such as public policies which are detrimental to youth, and improving community capacities of youth to be advocates for social change. Challenges for future practice and research are articulated.

INTRODUCTION

The concept of empowerment and its importance in health promotion for transforming unhealthy conditions has been evolving in the last two decades. This paper will present the theoretical and practical rationale for empowerment as a health-enhancing strategy, and make recommendations for adopting empowerment approaches in order to reduce health disparities. First, a review of powerlessness as a core social determinant will be conducted. Second, empowerment will be explored and compared with similar social protective factors, such as social capital and community capacity. Finally, a youth policy project in New Mexico, Youth Link, will be presented as a case study of empowerment in action.

POWERLESSNESS AND HEALTH DISPARITIES

The relationship between adverse material conditions and poor health outcomes, such as absolute poverty, physical deprivation, lack of sanitation, and toxic exposures, has been documented for centuries (1). The social determinants literature, however, has more recently been accumulating evidence that adverse psychosocial factors are also associated with poor health outcomes (2–4).

An evolution of studies has posed the question as to whether there exists a generalized psychosocial/immunological susceptibility to disease from social conditions (5, 6). Earlier studies have included research on federally designated poverty zones in Alameda County (7); on the inverse relationships between hierarchy and cardiovascular disease among British civil servants (8, 9); on the relationship between jobs with low control and high demand and higher disease rates (10, 11); and the chronic stress and lack of social support literature in their association with mortality (12).

In the last two decades, there has been a continued and dramatic increase in our understanding of social environments, such as workplace and neighbourhood characteristics, people’s experiences of discrimination and racism; the relationship between economic disparities/inequities and lack of social cohesion in all-cause mortality and morbidity; and policies which shape national and local environments (2–4, 13–16).

In workplace health, two dynamics have been identified as important: the lack of access to work, including unemployment; and poor working conditions, including little career mobility (17, 18). Neighbourhood conditions of concentrated disadvantage have been associated with poor health status, such as dilapidated housing or abandoned buildings, as well as social conditions of minimal safety or few investments in public services, which could lead to further social disruption (14, 19). Neighbourhood segregation and wider societal discrimination have also been associated with poor health outcomes, not only for the communities of colour but also for the effect on all populations in the region dominated by segregated neighbourhoods (20, 21).

There exists much documentation now of the relative income hypothesis, that greater polarization of wealth or income is associated with lower life expectancy and

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higher mortality cross-nationally and within individual countries (4, 22). Recently, there has been a surge of research examining the association between lack of social cohesion or social capital and increased homicide rates, all-cause mortality, and other morbidities (23, 24). Causal pathways are still unclear, whether or not social capital variables are causal, mediating, or confounding in their association with disparate health outcomes, and whether or not these variables should be seen as secondary to material conditions (25).

In sum, these studies suggest that living in an environment of physical and social disadvantage – being poor, low in the hierarchy, under poor working conditions or being unemployed, subject to discrimination, living in a neighbourhood of concentrated disadvantage, lacking social capital, and at relative inequity to others – is a major risk factor for poor health. Being powerless or, in Syme’s designation, lacking “control over one’s destiny” therefore becomes a core social determinant (26).

**EMPOWERMENT AS A HEALTH-ENHANCING STRATEGY TO REDUCE DISPARITIES**

With the convergence of social risk factors into an overarching construct of powerlessness, the question of how to combat powerlessness becomes critical. This question requires turning from theories of aetiology, which may point out targets of change, to theories of intervention, which hope to elucidate the most effective mechanisms and processes to bring about change. The key question becomes how to better understand the role of social protective factors in reducing disparities and risks of ill health due to these social determinants.

Social protective factors, as a broad term, include many parallel concepts, such as community empowerment, community capacity, community competence, social cohesion, collective efficacy, sense of community, and social capital. Together these concepts demand a new approach to developing theories of change for reducing disparities. Necessary questions to ask include questions of context, whether interventions to strengthen social protective factors vary by population, geography, or over time; and questions of methodology: how can communities enhance social protective factors and improve their ability to create effective health programmes? Most importantly for reducing inequities, a key question is: how do the social protective factors in any given community interact with its capacity to challenge unhealthy material conditions, even in the face of concentrated disadvantage or poverty?

Because social capital has gained prominence in the media and the public health literature, it is important first to dissect this concept. Social capital has been defined as the features of social organization (networks, trust, and norms) that facilitate coordination and cooperation for mutual benefit (27); or as a resource stemming from the structure of social relationships, which facilitate achievement of specific goals (28).

Within the public health literature, to date, social capital has been operationalized predominantly as a horizontal relationship between neighbours or community members, with variables like trust, reciprocity, and civic engagement such as in voluntary organizations, soccer leagues, or parent teacher organizations (23).

Despite some evidence of association to health outcomes, the ascendance of the construct “social capital” remains problematic. First, there is no evidence as yet that lack of social capital causes poor health outcomes independent of material conditions that inform day-to-day experience. Second, by focusing on horizontal relationships, the issues of power and vertical relationships between communities and the outside world are ignored, except for a novel reconfiguration of social capital as collective efficacy, which is the belief of community members that they have the capacity to create change (29). Third, the idea that social capital is a panacea in fact enforces a victim-blaming mentality: communities would be healthier if they just “got it together” themselves. Fourth, and very importantly, social capital as a concept has displaced many other community-level protective concepts, which continue to offer useful understandings of social environments and political change processes.

Two community-level concepts are much preferable in their broad perspective of social protective factors: community capacity and community empowerment. Within health education and health promotion, community capacity has become a prominent term, focusing on 10 dimensions: active participation, leadership, social protective factors, as a broad term, include many parallel concepts, such as community empowerment, community capacity, community competence, social cohesion, collective efficacy, sense of community, and social capital. Together these concepts demand a new approach to developing theories of change for reducing disparities. Necessary questions to ask include questions of context, whether interventions to strengthen social protective factors vary by population, geography, or over time; and questions of methodology: how can communities enhance social protective factors and improve their ability to create effective health programmes? Most importantly for reducing inequities, a key question is: how do the social protective factors in any given community interact with its capacity to challenge unhealthy material conditions, even in the face of concentrated disadvantage or poverty?

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The second term, community empowerment, has emerged from the confluence of several disciplines, community psychology (31, 32), health education (33), community organizing (34), and social work (35), and has now entered the WHO public health discourse (36). Defined as “a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life”, it clearly embraces political change and vertical relations.

The term “empowerment”, unfortunately, has been much abused in the media and in public discourse; often equated with individual self-concepts, such as self-esteem or self-efficacy; used by advertisers to
promote consumerism; or used by industry to promote a mythology of worker decision-making.

Yet community empowerment (purposefully using the term community empowerment, rather than empowerment alone) as a value-base and a theory has much to offer. As a value orientation, community empowerment applies the ethical basis of social justice and reduction of inequities to how interventions are chosen and structured. It challenges professional relationship to communities, emphasizing partnership and collaboration, rather than a top-down approach.

As a theory and methodology, community empowerment has developed significantly in the past two decades. First of all, empowerment includes both processes and outcomes, which may themselves lead to improved health status. Empowerment is context and population specific (32, 33).

Most importantly, for the theory, community empowerment is a multi-level construct, representing both processes and outcomes, for individuals, the organizations they work with, and their community settings (37). At the level of the individual, psychological empowerment best illustrates a concept that extends intra-psychic self-esteem to include people’s perceived control in their lives, their critical awareness of their social context, and their participation in change (38). Organizational empowerment incorporates the processes of organizations, whether or not they are acting to influence societal change, as well as outcomes, such as their effectiveness in gaining new resources. Community-level processes include people’s ability to work cross-culturally, as well as outcomes of transformed conditions.

Finally, power is central to the idea of empowerment, yet power too must be dissected to be understood. Theories of power range from a pluralist liberal democratic view of equal competing agendas to a view that power over others is represented by hegemonic and political-economic structures that favour certain interests or classes of people over others (39). These “power-over” structures are reproduced by ideology that reinforces power through excluding people from societal processes (40, 41).

Two competing notions of power are important for empowerment strategies: the first is from Foucault, who argues that power is not monolithic but represented as localized relationships which are inherently unstable, and therefore able to be challenged (42). The second notion is a feminist notion of power as power-with (not power-over), as a limitless expanding resource which comes from within and from collaborative work with others and leads to empowered communities as people empower themselves (43).

Empowerment, therefore, becomes inherently contradictory, as Labonte states, as “a dialectical dance, of power given and taken all at once”, embodying both resistance to power structures through community organizing and advocacy, and community-building efforts which strengthen community relationships and social protective factors (44).

Suggested here is a new community empowerment model for social protective factors at the community level, which incorporates both the horizontal community-building dimensions internal to the community, and the vertical community-organizing efforts to challenge “power-over” structural conditions.

At the horizontal level, individuals may engage in trust building, getting to know neighbours, and watching out for each other’s children. Community associations may foster these activities through house meetings or block parties, or may work together to improve programs within the neighbourhood. At the vertical level, individuals may join with others to advocate for new programmes, but to be more effective they would work with community organizations to advocate for new resources and leverage power from outside the neighbourhood.

Measurement of these dimensions of empowerment has also been developing over the last decade. At the individual level, horizontal relationships have been operationalized as trust, reciprocity, and civic engagement in the social capital literature (23, 45). Collective efficacy and social norm control have been operationalized in their relation to neighbourhood violence (24). Scales have been developed for the psychological empowerment dimensions of interpersonal beliefs of perceived control, interactional critical understanding of one’s social environment, and behavioural participation in social action (32). Sense of community has consistently held up as a predictor of health and participation (46, 47).

The concept of participation creates the link between the individual and organizational level, though measures have been more developed for evidence of individual participation in group activities. With sense of community, perceived neighbourhood control and neighbourhood participation have been found to be correlated with self-reported health status and depression (47). At the organizational level, network analyses and coalition measures have been developed to examine what constitutes an effective coalition, using predominantly internal measures, such as evidence of leadership development, role clarity, satisfaction, effective planning, and levels of collaboration (48, 49). Health outcomes may be direct or indirect. Direct health outcomes may result from coalition or neighbourhood activity to prevent siting of a toxic waste facility or to pass a clean air ordinance, which may lead to reduction of smoking behaviours. Indirectly, as a result of participation, social isolation may be diminished leading to improved health.
Despite the advance in measurement, there are limits to any tool or set of scales. Self-report measures cannot truly represent community-level understanding, which raises into question the ability of current social capital measures to portray a community's social fabric. Even on the individual level, they suggest a static concept, which does not account for the range of experience of any one individual or of communities over time. Qualitative approaches therefore can enhance understanding of the context, of dynamics of change, and of such outcomes as transformed conditions, new policies, practices, or political voice.

In sum, community empowerment theory includes processes and structural outcomes related to participation, control, and critical awareness, and suggests a relationship between increased empowerment as an intermediate outcome leading to improved health outcomes.

CASE: YOUTH LINK, A YOUTH POLICY PROJECT IN NEW MEXICO

A case study may best illustrate the processes and outcomes of community empowerment. For the past six years, Youthlink, a statewide leadership project, has been dedicated to developing a youth-driven policy agenda and preparing youth as advocates for local and state policy changes. Funded by the Kellogg and Surdna Foundations and local and state health resources, Youth Link's mission has been to create opportunities for youth, who are traditionally disenchanted, to organize with adult support so that their voices, their needs, and their strengths will be heard by policy makers.

Youth Link's strategy has involved youth aged 12 to 21 in intergenerational Community Action Teams (or CAT groups) throughout the state, to develop projects for their communities, to listen to community needs and to formulate action and policy plans. In the beginning, 14 CATs were initiated, representing the ethnic and geographic diversity of the state, including several tribal, Northern Hispanic towns and urban environments.

The New Mexico backdrop for this effort includes demographics and health statistics that pose challenges for any health intervention. Of 1.6 million people, the per capita income is 48th in the nation, with the third highest in percentage of families living in poverty, at 1.5 times the national average, and with uninsured rates for healthcare double the national average. Its ethnicity is: 37.5% Hispanic, 2% Black, 9% Native American, 50.4% Anglo. Twenty-nine of its 33 counties are rural, with towns of less than 2,500 people; 15 of those counties are designated frontier, with less than six people per square mile. Health statistics are also some of the worst in the nation: first in driving while intoxicated per capita, or per million miles driven; sixth in teenage pregnancy rate, and worst in access to care. All 29 New Mexican rural counties have farming or ranching, some with a boom/bust mining economy. Rural counties suffer from higher rates of poverty, and lack of resources equally distributed to population.

In the first two years of the project, Youth Link activities focused primarily at the community level, with the CAT teams engaged in a variety of local issues, such as reducing driving while intoxicated among teens, targeting underage drinking, and creating teen centres in rural areas. Policy was seen as ambiguous and too abstract for serious action.

It was not until the preparation for a statewide Youth Town Hall one and a half years into the process that youth began to develop true policy awareness. Focus groups around the state, led by youth facilitators, uncovered issues for the Town Hall agenda: substance abuse prevention; violence and crime; gangs; school issues; and teenage pregnancy. These focus groups also analysed social determinants, such as racism/discrimination (stereotyping, especially at school and by police); lack of support from adults (not being respected/listened to; poor adult role models; and family cycle of problems); and poor environments/poverty (including communication problems; negative media; unjust social and economic policies); and issues of self and peers (low self-esteem/peer pressure; and relationship abuse).

The Town Hall itself, a three-day youth-facilitated meeting involving 145 youth from around the state and 20 adults, turned the tide towards greater policy awareness and political efficacy of youth. Town Hall recommendations addressed the specific youth issues, as well as underlying concerns of social justice and equity for youth:

1. **Respect for youth**: Youth wanted to be listened to by adult political leaders, and wanted the opportunity to be involved in decision making. This included a call for lowering the voting age to 16.
2. **Schools**: Youth called for representation on school boards, as well as more equitable distribution of resources, between rural and urban school districts. To prevent drop-outs, they recommended “in-school suspension”, where young people would not be sent on the streets even with severe infractions of policy.
3. **Teenage pregnancy**: Youth wanted school distribution of condoms, especially in rural areas where accessibility was a greater problem, as well as reality-based sex education in schools.
4. **Drugs, alcohol, and tobacco**: Youth were concerned about adult hypocrisy, with their knowledge of adults’ abuse of drinking and smoking, while at the same time denouncing this behaviour in youth.
5. **Youth violence**: Youth took a broader perspective...
on the root causes of violence, citing family problems, racism, prejudice and hate, drug abuse/alcoholism, poverty, greed, and gangs. They called for more youth activities, drug-free safe places, community watch programmes, no weapons in schools, more jobs for youth, and greater inclusion of former gang members in youth outreach.

The last several years have focused on development of policy bills in the state legislature. For the 1999 legislative session, the youth CAT’s developed three memorials, or study bills: requesting that the State Department of Education study alternatives to suspension and expulsion of students; requesting that the State Departments of Education and Health examine the relationship between school sex education and teenage pregnancy rates; and requesting that tobacco retailers comply with the law that prohibits sales to minors.

Youth focus groups revealed a heightened collective efficacy and perceived control: “Testifying before the committees isn’t too bad if you’re prepared, know your stuff, and believe what you are saying.” “Most youth were just there to watch, but we were there to speak, to be heard!” One youth stated his reasons for participating: “What I want to do ... is to make a difference and effect change in [driving while intoxicated] policy in New Mexico to make this state a safer and better place for youth.”

Over a six-year period, Youth Link has evolved into a highly focused youth-driven policy project, with youth encouraged to participate in testimony, to develop ideas for youth bills, to critically analyse their situations, and to challenge adults to listen to their needs. Personal changes in political efficacy and collective efficacy are connected to their involvement in a state policy arena.

Although social determinants may not yet have been transformed, such as increased resources or youth jobs, involved youth have developed a critical analysis of the relationship between risky behaviours and lack of support by adults, lack of resources, and the greater connections to racism and stereotyping. Adult legislators have taken youth seriously in their inclusion of youth bills at the Legislature.

Lessons so far from Youth Link have been: the importance of finding adult allies to encourage participation; the importance of dialogue so youth can identify the connections between underlying issues and health symptoms, such as inequities between rural and urban regions; and the measurement of personal changes in political efficacy coupled with actual policy changes that affect the structure of how youth are viewed in the state.

Returning to the question asked in the beginning, how do you create a coordinated effort to combat powerlessness and reduce social disparities, it is clear that the process is lengthy. While the field still faces questions of the pathways between powerlessness, lack of social protective factors, material deprivation, inequities and poor health outcomes, community empowerment strategies are legitimate mechanisms for targeting social determinants.

The challenge remains how best to increase participation, control, and critical awareness; and to simultaneously transform material conditions and build community social protective relations. The second challenge is the importance of recognizing that community empowerment and social protective factors do vary in context, ethnic/racial populations, and developmentally over time. Ultimately, community participation will need to drive whichever are the best empowerment strategies that work within people’s own cultural context and political environments in order to change conditions of power and enhance health.

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