



What is the evidence on effectiveness of empowerment to improve health?

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ABSTRACT

This is a Health Evidence Network (HEN) synthesis report on the effectiveness of empowerment strategies to improve health and reduce health disparities.

The report shows that empowering initiatives can lead to health outcomes and that empowerment is a viable public health strategy. The key message from this review is that empowerment is a complex strategy that sits within complex environments. Effective empowerment strategies may depend as much on the agency and leadership of the people involved, as the overall context in which they take place.

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Summary

The issue

Within the last decades, social exclusion, disparities, and absolute poverty – almost 3 billion people living on less than US \$2.00 per day – have grown despite globalization and rising per-capita income in many developing nations. Income ratios of the richest 20% of the population to the poorest 20% are now at 82 to 1 compared to 30 to 1 in 1960. World-wide health disparities are increasing due to vulnerability to disease from severe malnutrition, rapid re-emergence of water and blood-borne infectious diseases, environmental degradation, disinvestment in the health infrastructure and violence. Within this same period, empowerment strategies, participation, and other bottom-up approaches have become prominent paradigms within public health and the development aid for reducing these disparities. As “empowerment” increasingly enters mainstream discourse, those using the term need to clarify definitions, dimensions and outcomes of the range of interventions called empowering.

Findings

Research on the effectiveness of empowerment strategies has identified two major pathways: the processes by which it is generated and its effects in improving health and reducing health disparities. Empowerment is recognized both as an outcome by itself, and as an intermediate step to long-term health status and disparity outcomes. Within the first pathway, a range of outcomes have been identified on multiple levels and domains: psychological, organizational, and community-levels; and within household/family, economic, political, programs and services (such as health, water systems, education), and legal spheres. Only a few researchers have used designs resulting in evidence ranked as strong in the traditional evidence grading systems. Yet there is evidence based on multi-level research designs that empowering initiatives can lead to health outcomes and that empowerment is a viable public health strategy.

Much research has been focused on empowerment of socially excluded populations (e.g., women, youth, people at risk for HIV/AIDS, and the poor), though application of empowerment crosses to other populations and issues in public health. Youth empowerment interventions have produced multiple empowerment and health outcomes: strengthened self- and collective efficacy, stronger group bonding, formation of sustainable youth groups, increased participation in structured activities including youth social action, and policy changes, leading to improved mental health and school performance. Multi-level empowerment strategies for HIV/AIDS prevention which address gender inequities have improved health status and reduced HIV infection rates. Women's empowering interventions, integrated with the economic, educational, and political sectors, have shown the greatest impact on women's quality of life, autonomy and authority and on policy changes, and on improved child and family health. Patient and family empowerment strategies have increased patients' abilities to manage their disease, adopt healthier behaviours, and use health services more effectively, as well as increasing care-giver coping skills and efficacy. Coalitions and inter-organizational partnerships that promote empowerment through enhanced participation and environmental and policy changes have led to diverse health outcomes.

Policy considerations

In light of the evidence and other information available up to now, effective empowerment strategies are needed for socially excluded populations. While participatory processes make up the base of empowerment, participation alone is insufficient if strategies do not also build capacity of community organizations and individuals in decision-making and advocacy. The policy considerations based on this narrative literature review include the following:

- Successful empowering interventions can not be fully shared or “standardized” across multiple populations, but must be created within or adapted to local contexts (e.g., culture and gender appropriateness).

- Specific population programmes to overcome the larger political, social, racial, and economic forces that produce and maintain inequities need to be developed and further evaluated.
- Structural barriers and facilitators to empowerment interventions need to be identified locally.
- Empowerment strategies, including community-wide participation, seem worthwhile to be integrated into local, regional and national policies and economic, legal, and human rights initiatives.
- Health promotion should address effective empowerment strategies, such as:
 - increasing citizens' skills, control over resources and access to information relevant to public health development;
 - using small group efforts, which enhance critical consciousness on public health issues, to build supportive environments and a deeper sense of community;
 - promoting community action through collective involvement in decision-making and participation in all phases of public health planning, implementation and evaluation, use of lay helpers and leaders, advocacy and leadership training and organizational capacity development;
 - strengthening healthy public policy by organizational and inter-organizational actions, transfer of power and decision-making authority to participants of interventions, and promotion of governmental and institutional accountability and transparency; and
 - being sensitive to the health care needs defined by community members themselves.
- The most effective empowerment strategies are those that build on and reinforce authentic participation ensuring autonomy in decision-making, sense of community and local bonding, and psychological empowerment of the community members themselves.
- Government investment in multiple-method research and evaluation designs to collect evidence on the impact of empowerment strategies over time is needed.

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Introduction

In the last three decades, health professionals, non-governmental agencies, multi-lateral and bilateral aid agencies, foundations, and governmental agencies have increasingly turned to empowerment and community participation as major strategies for alleviating poverty and social exclusion and reducing health disparities. Within the non-governmental sector, empowerment and other bottom-up approaches have become the dominant community development paradigm (1), in contrast the top-down strategies of the 1960s and 1970s (2).

Worldwide, almost three billion people live on less than US \$2.00 per day and 1.1 billion on less than \$1.00 per day, the absolute poverty line established by the World Bank. In 2000, women accounted for 70% of those living below the absolute poverty line (3). Three-fifths of the 4.4 billion people in developing nations lack access to basic sanitation, with more than one billion without clean water (4). Poverty is not unique to the developing world. In 2003, the United States reported 36 million people living below the American poverty line of US \$14 680 per year for a family of three. Investments in improving market economies and per capita GDP have not guaranteed improvements in health, partly due to structural adjustment and debt repayment requirements that have moved money away from health and social spending (4,5). Improvements in the per capita GDP may improve health indicators such as life expectancy, but do not accurately reflect growing health inequities (4,6,7). Both relative and absolute poverty create vulnerability to disease as the poor are particularly susceptible to poor sanitation and nutrition, inadequate public health infrastructure, human rights violations, hunger and psychosocial stressors from powerlessness and despair (8–11).

This paper will present an overview of the processes by which empowerment outcomes are generated and the effects of empowerment strategies on public health and health disparities. Furthermore, it deals with describing the specific characteristics and contexts for successful multi-level empowerment approaches including governmental policies and actions in the legal, economic and political arenas.

Sources for this review

This paper is based on a literature review of published, English language, peer-reviewed literature from public health and community psychology. Research studies, meta-analyses, and reviews were solicited from PubMed, PsycInfo, Cochrane, DARE and the Campbell Collaboration databases, with additional searches based on bibliographic information from identified articles. In addition, the grey literature was reviewed from the following websites of aid agencies, foundations, professional associations, and governmental agencies which espouse empowerment or equity strategies: the World Bank, the World Health Organization, the Centers for Disease Control and Prevention, the Rockefeller Foundation, the International Society for Equity in Health, the Pan American Health Organization, UNICEF, Health Canada, and several NGOs, such as Self Employed Women's Association (SEWA).

A search for articles on community participation in water and sanitation projects created a complementary literature review, because of the direct benefit of water to health and the integration of women's empowerment into these projects (as women are largely responsible for hauling water). Seminal work in rural development also points to the importance of community participation for changing environmental conditions (12-14).

In this narrative HEN review, the focus is on empowering approaches to health. Search terms included: empowerment, health, outcomes, community participation, health disparities, coalitions, evaluation, and empowerment intervention. Searches yielded nearly 4000 articles of which 500 were reviewed in depth. Included are quasi-experimental comparative designs, qualitative descriptions of community change, meta-analyses, outcome evaluations, case studies, reviews, and correlations of surveillance data with program information in a comprehensive literature review (15).

Articles were selected for review if they represented the broad definition of empowerment that integrates psychological empowerment within organization and community level changes, and within

multiple spheres of peoples' lives. The literature on individual level empowerment, including patient compliance, self-care, and education; and behaviour change is also presented in a discrete section (based on articles from Cochrane Collaboration as well as the other data bases). In sum, articles were included which clearly define the field and present evidence of empowerment outcomes, and of health and development outcomes related to community empowerment initiatives.

Except for seminal conceptual articles, articles were excluded if they focused exclusively on theory or if they did not seek to link interventions with evaluation outcomes.

It was not appropriate to apply specific comparison criteria as in a systematic literature review, because community empowerment interventions are by their nature complex, dynamic and comprehensive. These interventions which comprise simultaneously many target populations as well as empowerment and health outcomes at many levels (individual, organizational, and community) are nearly impossible to evaluate traditionally. (See Annex 1 for definitions and dimensions of empowerment, and Annex 2 for discussion on evaluation of empowerment interventions).

Findings

This chapter will review the evidence on the characteristics of participatory empowering strategies and interventions, followed by an examination of the research evidence on empowerment outcomes, and their potential to lead to health and development outcomes.

Evidence on participatory empowering strategies

Citizen participation seems critical in reducing dependency on health professionals, ensuring cultural and local sensitivity of programs, facilitating capacity and sustainability of change efforts, enlisting community stakeholders in program improvement, enhancing the productivity, effectiveness and efficiency of programmes and enhancing health in its own right (16–20). Key facilitators to participation are the use of local opinion leaders (i.e., village chiefs, traditional healers, religious leaders), lay health workers (21–23) and social movements (24, 25), political will (i.e., governments that sponsor or mandate mass mobilizations) (26, 27) and use of culturally based and culturally competent interventions (28–31). Studies on coalitions and intersectoral partnerships, between academic institutions, government agencies, NGOs, and communities, have documented a wide range of facilitators of coalition participation and effectiveness (32–43). Effective leadership that promotes participatory decision-making as well as oversight is potentially the most important characteristic of a community's capacity to promote participation (44).

Participation should be seen as a complex and iterative process, which can change, grow, or diminish based on the unfolding of power relations and the historical/social context of the project. It is not controllable or predictable in its outcomes, and happens with or without professionals. Therefore professionals' role should shift from dominant to supportive or facilitative (45).

A few studies have examined psychosocial barriers to participation such as low perceived value or weak leadership (46), whereas the majority have documented cultural and structural barriers. Cultural barriers include unequal power dynamics so that collective action is made difficult for marginalized populations such as youth, women, or injection drug users (47–50). Institutional barriers remain prominent: bureaucracy or political barriers, including authoritarian regimes (51,52), high social stratification (53), a history of poor experience of participation in government or top down implementation (46), racism (54) and a lack of representativeness in participating members (16), lack of management, organization and resource mobilization expertise or conditions supporting participation (17, 55). Many of these barriers are hidden. Power relations within communities may be concealed, such as those based on ethnicity, gender, caste or age, or between facilitators and community participants and between donors and beneficiaries (56). Participation can be constrained by development experts' unwillingness to challenge internal power relations, lack of knowledge about

empowerment, or unwillingness to extend beyond engaging key informants in order to genuinely facilitate community decision-making (48,57).

While participation forms the backbone of empowering strategies, participation alone is insufficient and can be manipulative and passive, rather than active, empowering and based on community control (58,59). It can be viewed as utilitarian, i.e., to assure program efficiency (60), rather than empowering with goals to reduce social exclusion (61). Participatory methods themselves at a local level may be limited – engaging community members as no more than informants (61) – or may obscure the need for analysis of larger institutional structures and policies which can override local determinants of well-being (62). Questions to pose within any community include: who are the official representatives, whose voices remain hidden, and what are the power inequalities which may prevent participation of certain sectors (63).

The World Bank has identified four characteristics to ensure that participation is empowering: people's access to information on public health issues, their inclusion in decision-making, local organizational capacity to make demands on institutions and governing structures and accountability of institutions to the public (64). Rifkin has added the important factor of human rights (45,65). A significant strategy to counter exclusion and promote empowering participation is community control of project funding (29). In minority communities, in particular, empowerment interventions should support minority leadership, recognize potential for cross-cultural conflict, and build on existing strengths (66).

While specific empowering interventions differ, the majority of the interventions worldwide support participatory strategies that are based on group dialogue, collective action, advocacy and leadership training, organizational development, and transfer of power to participants.

Empowerment outcomes

Much of empowerment literature focuses on participatory empowering strategies that lead to outcomes as ends in themselves, yet they are also intermediate steps to health and development outcomes. Most of the literature on empowerment outcomes centres on psychological empowerment (67), measured by collective efficacy (the belief that people together can make a difference) (68), outcome efficacy (the belief that one's actions can produce results) (69), political efficacy (the belief that one can influence the political process, organizations and communities) (70–72), critical thinking ability (73) and participatory behaviour.

Much research has accrued on the interconnectedness of psychological empowerment, level of participation and a sense of community (i.e., people's identification and bonding with their social networks or place of residence). Community participation is facilitated by an existing sense of community and psychological empowerment; psychological empowerment and sense of community, in turn, are promoted by participation. The sense of community is a particularly robust predictor of involvement in neighbourhood and community action (74–76). Other socio-psychological variables also facilitate increased participation. In a youth healthy heart advocacy initiative, participation was significantly associated with youth's sense of community, perceived value of health, psychological empowerment and perceived policy control (77). Psychological empowerment was significantly associated with increased participation, sense of community and positive organizational climate in youth tobacco control interventions and community coalitions (78,79).

A study of a housing improvement interventions in low-income communities found that participation and perception of others' participation predicted quality and empowerment on both individual and group levels (80). A New Zealand study of predictors of participation of community residents in "resident action groups" found increased perceived benefits, satisfaction with group processes and sense of community and decreased perceived costs of participating (81). A study of Honduran women market vendors in an urban primary care centre identified demographic, contextual, and women's

psychological variables – including perception of influence and sense of community – as important for their participation (82).

Much literature has focused on the correlations between participatory empowering strategies and project effectiveness in organizational empowerment, through greater efficiency, sustainability, and more equitable distribution of services (64, 83–86), especially in water and sanitation development projects. In a meta-analysis of prevention programmes for child maltreatment, empowerment approaches based on participant involvement and social support were found to increase programme impact (87). A study on village water committees showed that institutional transparency and accountability, access to information and participation, emerged as most important for equity of services and committee effectiveness (88).

Community empowerment outcomes include community bonding measures – social capital (89–91), neighbourhood cohesion (92), neighbourhood influence (93), sense of community (94), community capacities or assets (95,96) – community measures of participation, such as extent of civic organizations, and also objective changes in healthy public policies, transformed norms, greater equity, and improved material conditions (73). Community and national level empowerment variables within the political, economic, legal, and human rights sectors include good governance, institutional accountability, and women's empowerment (64,97,98). Good governance includes accountability of politicians and managers through an information flow to the public, enhanced civil liberties, lower corruption, and increased responsiveness of an institution to public health needs and problems, and reciprocal relationships with a public empowered with greater access to transparent information and control over resources. Civil liberties and community participation, which facilitate transparency, for example, have improved development effectiveness (86), increased expenditures in schools (64,99), and shaped health sector services, including increasing health centre attendance (45,100,101). Women's empowerment is measured at the national level by the percentage of women in political office and management positions and women's share of earned income (102); at the household level it is measured by land ownership, autonomy and authority in decision-making, mobility and levels of domestic violence (103).

Aggregated regional and national data, despite their allure for making comparisons, must be used with caution as empowerment outcome measures. While the unit of analysis of an empowerment intervention can be multi-level (at a minimum, the participants and local organizational or policy changes), the ability to create regional or national change, such as the percentage of women in political office, is dependent on many more actions than a single intervention. Exclusive reliance on national and regional data also can lead to false interpretation of the success or failure of an empowerment initiative that may be facing intransigent national bureaucratic and political structures. Empowerment outcomes, therefore, must be assessed at many levels simultaneously and over time for an accurate picture.

Health and development outcomes

Linking community and psychological empowerment to health has been more difficult. An important study in Detroit, however, identified greater sense of community (the strongest predictor), perceived neighbourhood control, and neighbourhood participation as independent predictors of better self-reported health and fewer depressive symptoms (93).

Only a few published studies were found that explicitly tested the hypothesis that community participation in decision-making would show additional benefits in health or health care. In the late 1980s, a quasi-experimental study on water supply in Togo and Indonesia including an active participation group, a top-down intervention group where water systems were installed without participation, and a control set of villages (104) found that 25–30% more children were immunized in the villages with active participation. The study showed that increased community participation in water projects was correlated with improved child health strategies. A comparative study of two drinking water supply and sanitation projects (one with active villager participation and one without)

documented a range of better outcomes in the active villages: better water quality, higher percentage of people understanding the risks and switching to the safe water supply (40% vs. 25%), better monitoring of tap functioning and maintenance, better health habits in using latrines and filtering drinking water and higher levels of satisfaction (75% vs. 30%) (85). In Ghana, a schistosomiasis control programme compared the provision of chemotherapy with three village conditions of health education: a participatory action approach, a passive approach, and no health education. With a baseline showing limited knowledge of the disease and its prevention in all villages, after the intervention, the participatory villages more successfully constructed school pit latrines and weeded the river banks, though all constructed hand-dug wells (105,106). A quasi-experimental design in Norway with an empowerment intervention fishing village and three control villages attributed improvements in cardiovascular risk factors to integrated involvement of the fishermen within many sectors, such as schools and worksites, the health care system and local government (107).

The evidence of empowerment interventions on different subpopulations to achieve both empowerment and health results includes patients and health care consumers; and those populations particularly at risk for social exclusion and disempowerment, i.e., youth, people at risk for HIV/AIDS, and women.

Patient or consumer empowerment strategies

Patient or consumer empowerment has emerged in the last decades as a proactive partnership and patient self-care strategy to improve health outcomes and quality of life among the chronically ill (108,109). Empowerment interventions, often consisting of support groups, educational opportunities, caregiver empowerment, patient decision-making, changes in health care services and advocacy efforts, have been actively pursued in diabetes care and other chronic diseases (110–115), chronic obstructive pulmonary disease (116), end-stage renal disease (117), osteoporosis (118), disabilities (119), cancer (120–122) and mental disorders (109,123–125). Self-management education for diabetes patients has shown impact through two systematic reviews; eleven studies of group-based education found improvements in diabetes control, knowledge and need for medication, associated with increased self-empowerment, self-management skills and treatment satisfaction (126). Seventy-two studies showed short-term effects in self-management, dietary habits and disease control, with empowering characteristics such as patient decision-making and small group dialogue more effective than didactic sessions (127).

In addition to personal patient empowerment, family empowerment strategies have increased caregiver efficacy, coping skills and access and effective use of health services. Family strategies have seen greatest use in mental health (128,129), including reduced anxiety and depression in caring for chronically ill children (130). Support group interventions with grandparents and a systematic review of 20 studies of parent training to improve maternal psychosocial health showed reduced depression, anxiety and enhanced empowerment (131–132).

Evidence shows that health outcomes in patient empowerment strategies take place through several pathways: directly – through improvements in individual decision-making efficacy, disease complication management and improved health behaviours (111–113,117,133) – and indirectly, through strengthened support groups, caregiver empowerment, enhanced satisfaction with provider/patient relationships and better access and efficient use of health services, with evidence of reduced utilization (111–113,116), enhanced self-education (134) and improved mental health outcomes (130,135). Mental health empowerment programmes that focus on advocacy place the patients in helping roles, which enhances their social support and quality of life and can create policy and practice changes such as improved quality of recreation services (136), new respite facilities, coalitions against stigma, and consumer rights policies (137).

In sum, patient empowerment and family caregiver interventions have shown improved self-regulated disease management, use of health services and mental health. While not all studies measured

individual empowerment outcomes, interventions with empowering characteristics, such as promotion of patient partnership and mastery over their condition, and use of group educational sessions facilitating a supportive environment and dialogue, have shown significant impact in improving health and quality of life in chronically ill patients. Advocacy interventions show additional benefits.

Youth empowerment strategies

Youth health empowerment strategies, promoting young people as participants in all aspects of programme design and as advocates for community norm and policy change, are growing (138–140). Empowerment strategies (as distinct from positive youth development approaches) emphasize awareness of feelings of powerlessness and power (49), the manner of participation, and whether young people believe they are able to influence public health issues and policies. It is not just the quantity of attendance at a structured activity, but the quality and intensity of active involvement (141,142) that are significant, as well as involvement of participants as decision-makers and social change advocates.

Evidence shows that engaging young people in structured organized activities that link them to each other and to institutions enhances their self-awareness and social achievement, improves mental health and academic performance and reduces rates of dropping out of school, delinquency and substance abuse (77,143,144). Empowerment components, such as viewing youth as a resource, engaging them in group bonding through dialogue, and involving them as decision-makers in their social actions, have been demonstrated in many programmes producing a range of outcomes: the Adolescent Social Action Program (145–147), Youth Empowerment Strategies (148), Youth Link (149,150), Youth Empowerment and Support Program (151), HOPE (152) and a Peruvian youth club project (153). A comprehensive youth empowerment initiative for tobacco control in 17 American states found enhanced psychological empowerment, youth participation in policy changes (154) and suggested the importance of group climate, adult and community support (140,155).

In sum, youth empowerment interventions have been related to various empowerment outcomes: strengthened self and collective efficacy, stronger group bonding, formation of sustainable groups, increased participation in social action and actual policy changes. These empowerment outcomes in turn have been linked to improved health and educational outcomes.

Empowerment of people at risk for HIV/AIDS

Programmes targeting HIV/AIDS prevention have increasingly turned to empowerment strategies focused on high risk groups: sex workers, injection drug users, men having sex with men who are not homosexually identified. Participatory research, using indigenous knowledge and peers from the community, has been shown to improve outreach and to create community ownership of programmes (156,45). Programmes such as the Mpowerment project for young gay and bisexual men (157) have shown that psychological empowerment and social bonding outcomes can influence the social context of gender relations. For example, a Latina women immigrants programme in San Francisco influenced communication comfort, changes in traditional gender roles and decision-making power (158) and an HIV/AIDS empowerment project for Mexican-American gay men reported greater condom use (159). Studies of female condom use have indicated effectiveness from over two dozen studies worldwide on a range of psychological empowerment outcomes, with women's ability to negotiate safer sex leading to reduced HIV and STD incidence. The interventions that fostered women's empowerment in the larger context of reproductive autonomy may be more effective than approaches limited to providing female condoms (160).

Evaluation of a two-year drug demand reduction programme aiming to build village and local government capacity in Northern Thai villages showed successful implementation and decreased numbers of drug users. Six months after termination, however, a lack of sustainability was attributed to insufficient empowerment of village leaders (161). It may be, however, that the time frame was far

too short to promote sustainability, with outside catalysts needing to stay longer (42). Sustainability was also evaluated in the 12 year-old Sonagachi intervention that has successfully reduced HIV infection and increased condom use among sex workers in Calcutta (162,163). Its success was attributed to an evolving empowerment model, including the use of peer outreach workers, broad community concerns as the starting point of the project, leadership development of the women, support by health professionals; and the eventual ceding of leadership to a new sex worker association. Replication of this study has shown similar evaluation outcomes (164).

In sum, HIV/AIDS prevention empowerment strategies that address gender inequities have improved health status by increasing condom use and reducing HIV infection rates.

Women's empowerment

There is a lot of research on the importance of the social contextual influences that contribute to discrimination and the social exclusion of women. There is a need, therefore, to incorporate women-specific issues into empowerment interventions (165). Improved education for women, including adult literacy and empowerment have been associated with improved child health (166,167) and reduced fertility (168). Although increasing educational opportunities for women is critically important, micro-enterprises have been identified as a faster route to improving health, on the hypothesis that women with income-generating power will spend their resources on family and children's health. It is not enough, however, to increase women's percentage of household income (169); this must be accompanied by increasing women's autonomy, mobility, decision-making authority and power within the household. Micro-enterprises and other income strategies may also impose additional burdens on women's workloads, because unpaid household work does not decrease (170). While difficult to evaluate because of selection bias and the aggregated effects of national health campaigns, a series of studies on the Bangladesh Grameen Bank and Bangladesh Rural Advancement Committee (BRAC) have shown increases in women's empowerment (171), with greater demands for health care (172), improved nutrition and contraceptive use (173), and increased immunization and lower child mortality rates (174,175). To a lesser degree these benefits also accrue to non-participating women in villages that provide micro-credit opportunities, showing the importance of community norms in improving women's empowerment and family health (103). A meta-analysis of 40 women's empowerment projects showed a wide range of quality of life improvements, including increases in women's advocacy demands and organizational strengths, enhanced services, and policy and government changes as a result of the advocacy (176), with some organizations showing transformed economic conditions for the women (177,178).

An evaluation (179) of a four-year NGO-government integrated effort to reduce maternal mortality showed community development of plans for emergency transport systems in 80% of the participating villages, a five-fold increase in women's plans to delay pregnancy and awareness of danger signs, greater community participation and formation of new lay health worker associations. Expectations are for reductions in maternal mortality and morbidity as participation is sustained. Integrated efforts that include reproductive health, family planning, maternal and child health, with income-generating activities, literacy, and primary health care have increased project implementation throughout villages (180). An integrated child nutrition programme empowering women to share information, and learn problem-solving and child care skills in women's supportive environments improved children's food intake and reduced severe malnutrition (181-183).

Some studies have examined the impact of women's political leadership on women's lives. A national constitutional amendment in India, which gave women the right to be elected to village councils rather than appointed, resulted in nine villages voting for all women's slates (184). Outcomes in three of the villages four years later showed collective action by both men and women to increase fuel, water and fodder in households. Results also included an increase in women's mobility and decision-making, closure of liquor dens – resulting in less wife-beating – and more girls attending schools. A study of women dairy farmer empowerment showed increased participation in management, collective self-

efficacy in household decisions, efficiency of milk production, household funds, and anti-alcohol campaign successes (185).

Village, lay or community health worker interventions are a key empowerment strategy which primarily engage women in a continuum of care: from natural helpers, to paraprofessional extenders of primary health care services, to health educator aides, to advocates for community health issues (23). Though there is an abundance of literature describing CHW outreach activities, the literature on health impact is less (31,186,187). Much effectiveness has been shown in health care utilization, especially of preventive screening services i.e., improved mammography (188); in patient behaviours, namely, completion of health education programmes (189); and a few studies on improving health outcomes, such as improved and less-costly immunization coverage (190) and decline in malaria morbidity (191). A meta-analysis of 15 studies (out of a review of 43) showed improved immunization and respiratory and malaria outcomes (192). Some studies have also included the empowerment of the CHW themselves: increased social support, leadership, and advocacy development (193).

In sum, interventions that have been most integrated with the economic, education, and/or political sectors have resulted in greater psychological empowerment, autonomy and authority, and have substantially affected a range of health outcomes.

Empowerment through intersectoral organizing and coalition efforts

Strategies for empowerment interventions for socially excluded populations have increasingly relied on intersectoral organizing and coalitions. Those inter-organizational efforts that have documented health outcomes have tended to have a highly specific health focus and have undertaken direct actions to address the problem (194,195). Examples include: hog industry pollution practices (196), health and safety conditions for hotel workers (197), housing conditions (198), environmental hazards (199), immunization rates (200, 201), infant mortality (202); disparities in diabetes care (203, 204) and neighbourhood safety (205). Internationally, interventions have used community mobilization strategies (5) to improve efficiency and equitable distribution of services, reduce institutional barriers of government, enhance participation in local government, strengthen civil society associations and create healthy public policies which themselves lead to improved health. Some of these efforts include river blindness campaigns (206) and strengthened district health systems, leading to improved maternal-child health (207).

Discussion and Conclusions

It is clear from the range of literature that empowerment strategies are promising in their ability to produce both empowerment and health impacts. The literature shows a consistency of empowerment strategies and outcomes, at the psychological, organizational and community levels, and across populations, though specific outcomes vary by issue and social context. The few articles that apply a more rigorous comparative design to document the added value of participation and empowering processes are indicative that empowerment has emerged as a viable public health strategy. The ability to sustain these impacts and expand beyond the local context are important challenges. There are clearly limits to locally-based or specific population programmes for overcoming political, socio-economic or institutional forces that maintain inequities.

Empowerment strategies are more likely to be successful if integrated within macro-economic and policy strategies aimed at creating greater equity. For example, a striking decline of child mortality in Bangladesh illustrates the importance of national integration, which included government policies to reduce poverty, women's empowerment and income generation, aggressive maternal child health campaigns and reliance on NGO programmes that provided opportunities for local decision-making and involvement (208). Case studies have shown that synergy between all elements (anti-poverty strategies, NGO-government collaboration, empowerment and participatory development and active

health programmes) is probably most effective at improving health and development outcomes (6). Studies of women in political office provide additional supporting evidence of the interaction with national legislative policy. For example, authority for the election of women to village councils increased local participation in improving the quality of life for women, girls and their households (184).

In the light of the evidence and other information, empowerment strategies are promising in working with socially excluded populations. While participatory processes are at the base of empowerment, participation alone is insufficient if strategies don't also build capacity to challenge non-responsive or oppressive institutions and to redress power imbalances.

The key message from this review is that empowerment is a complex strategy that sits within complex environments. Effective empowerment strategies may depend as much on the agency and leadership of the people involved, as the overall context in which they take place. Future actions therefore should consider the following:

1. integrate the following effective shown empowerment strategies into overall health promotion strategies:
 - a) increasing citizens' skills, access to information and resources,
 - b) using small group efforts to enhance critical consciousness and build supportive environments and a deeper sense of community,
 - c) promoting community action through collective involvement in decision-making and participation in all phases of planning, implementation and evaluation, use of lay helpers/leaders, advocacy and leadership training, and organizational and coalition capacity development,
 - d) strengthening healthy public policy through organizational and inter-organizational actions, transfer of decision-making authority to participants of interventions and promoting/demanding transparency and accountability of government and other institutions and
 - e) having community members define and act on community needs, including as health consumers;
2. build on documented successful strategies for marginalized populations (e.g., youth, those at risk for HIV/AIDS, women, and the poor), and supporting partnerships and coalitions that work with them (these strategies support participation which promotes autonomy and decision-making authority, sense of community and social bonding, psychological empowerment and action which leads to change in local circumstances);
3. build on successful patient and family caregiver strategies to re-orient health services toward making patients and families as resources in improving their health;
4. strengthen connections between the three linked empowerment outcomes: participation, psychological empowerment, and sense of community best developed by strategies which build on existing sense of community and cultural networks;
5. invest in research that uses mixed method and comparative design evaluation: experimental designs can be used for defined interventions with specific populations, yet the broad empowerment initiatives require a range of methodologies that examine programmes within the socio-political context, and multiple effects modelling can examine the interactions among psychological, organizational and community levels;
6. invest in research designs that test the hypothesis of the added value of participatory empowerment strategies to promote health outcomes: it is important for policy makers to understand that the changes in empowerment outcomes, such as psychological empowerment,

institutional accountability or community policies, can be sufficient evidence of a successful programme even if changes in health outcomes have not yet occurred, especially at the regional or national levels;

7. foster the refinement of measurement tools of empowerment domains and levels: universal instruments, however, may be insufficient and will require indicators based on local culture, language and context, in addition to qualitative methods to assess facilitators and barriers to change;
8. foster training for health and development professionals, service providers, policy makers and community leaders on community empowerment strategies and participatory research and evaluation, including partnership decision-making practices, ethical principles, power dynamics, inter-organizational skills and support for authentic community participation; and
9. support multi-level interventions integrating community empowerment with national and regional policies to enhance economic, political and human rights opportunities in order to have greater effect on reducing health disparities and social exclusion.

Annex 1. Empowerment and related concepts: definitions and dimensions

Social exclusion and inequities

Social exclusion is defined as living in conditions of deprivation and vulnerability, such as poverty; inadequate access to education, health and other services; lack of political influence, civil liberties, and human rights; geographic isolation; environmental exposures; racism or historical trauma; disruption of social capital and social isolation; exposure to wars and conflicts; alienation or powerlessness. Defined by the International Society for Equity in Health, global inequities (or disparities) of health are the “systematic differences (potentially remediable) in one or more aspects of health across population groups defined socially, economically, demographically or geographically” (209).

With new opportunities, socially excluded populations have the capacity to move beyond their restricted life conditions (210). Cultural practice and transmission are historical processes in which people’s “views and practices are dynamically affected by social transformations, social conflicts, power relationships and migrations” according to Guarnaccia and Rodriguez (211). People continually produce meaning in their social transactions, their identity (212) and in how they redefine their relationship to structural constraints (213,214). Empowerment strategies therefore need to focus on enabling marginalized groups to create and recreate their social norms, to seek changes in inequitable conditions, to develop cultural and cross-boundary identities, and to gain access to social resources that promote health.

Empowerment

In 1978, the World Health Organization’s Alma Ata Declaration first articulated the goals of community participation and equity, with subsequent extension to empowerment in the Ottawa Charter and Jakarta health promotion declarations (215–217). The bringing together of health with social and economic development has been a relatively recent phenomena, with the 2000 United Nations Millennium Development Goals, which included women’s empowerment and health interventions (218), the World Bank’s Strategic Framework and poverty reduction strategy, which identified empowerment of poor people as one of two priority strategies to improve development effectiveness (64), and the Commission on Macroeconomics and Health, which has advocated health sector investments for economic growth in developing nations (219). Because empowerment has entered the mainstream multilateral, bilateral and government agency discourses (with potentially different meanings), it is important to clarify the dimensions of the term.

Community empowerment has roots in community psychology, health education and health promotion, liberatory adult education, community organizing, rural and community development, and social work (220). Empowerment has been defined as “a process by which people, organizations and communities gain mastery over their affairs” (221); with community empowerment as a “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” (73).

The World Bank has defined empowerment as “the process of increasing capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes” to ‘build individual and collective assets, and to improve the efficiency and fairness of the organizational and institutional context which govern the use of these assets’ (222) and the “expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives” (64). WHO health promotion strategies have described community action and empowerment as prerequisites for health (215,216).

Empowerment is an action-oriented concept with a focus on removal of formal or informal barriers, and on transforming power relations between communities and institutions and government. It is based on an assumption of community cultural assets that can be strengthened through dialogue and action (223). It is exercised in various domains, from personal through political and collective action (224,225). Empowerment has sometimes been used interchangeably with community capacity (95), or social capital (226), though, unlike social capital, empowerment focuses on power relations and intervention strategies. Empowerment includes both processes and outcomes, with empowerment of marginalized people an important outcome in its own right, and also an intermediate outcome in the pathway to reducing health disparities and social exclusion.

Empowerment is culture, society, and population-specific and therefore requires action within the local context. Much has been written on empowerment as a multilevel construction, with psychological empowerment being people's self-efficacy and control in their lives, organizational empowerment the ability of an agency to influence change and community empowerment the ability to change real conditions (67, 227). Empowerment cannot be seen as a stand-alone strategy, but is part of a comprehensive approach, engaging policy-makers to promote structural or legal changes to support community engagement. Ultimately, empowerment is a dynamic interplay between gaining internal skills and overcoming external structural barriers to accessing resources (228). (Figures 1 and 2 illustrate the framework for empowering intervention strategies, empowerment outcomes, and their potential impact on health disparities and development effectiveness.)

Power is central to the idea of community empowerment with two core aspects based in relationships with others: control over resources (material, human, financial); and control over ideology (values, attitudes, beliefs) (2). Power over others may be exercised through direct or indirect control over peoples' opportunities to education, employment, living conditions, or other politico-economic structures that favour certain interests or classes of people over others. Ideologies work further to exclude people from social processes and control, most insidiously by creating quiescence, whereby people restrict their own possibilities (229,230). In addition to repressive power, Michel Foucault articulated another view of power as productive, leaving open the possibility of resistance (231). Power is conceptualized as a web of discourses and practices found in institutions, communities, and families, exercised through actions in a multiplicity of relationships. These power relationships are inherently unstable, and therefore able to be challenged. Feminism has introduced a view of power as being intrinsic, the "power within" to express one's voice; and as a limitless expanding resource, which as "power with others" leads to empowered communities as people empower themselves.

Empowerment strategies therefore mean challenging control and social injustice, through political, social, and psychological processes that uncover the mechanisms of control, the institutional or structural barriers, the cultural norms and social biases, and therefore enable people to challenge internalized oppression and to develop new representations of reality. Empowerment can be seen as a dynamic interplay between gaining greater internal control or capacity (personal transformation/psychological empowerment) and overcoming external structural barriers to accessing resources (community or institutional transformations) (228). As Gita Sen argues, it is not inevitable that having internal or intrinsic power leads to greater community control over resources, or vice versa, but there are many examples in development where policy transformations or social movements have enabled people from the bottom to gain psychological empowerment, or where a focus on consciousness-raising about root causes has led to structural changes (2). Both need to occur for sustainability.

Empowerment processes world wide have benefited from the liberative educational philosophy of Brazilian Paulo Freire, who articulated a consciousness-raising process emanating from a continuous cycle of dialogue and action (223). Dialogue, or participatory critical reflection in interaction with others about barriers, norms, and institutions, enables the development of collective actions, for further reflection, leading to further action, in an ongoing cycle. Starting in literacy education for slum dwellers and peasants in Brazil, Freire's work has been adapted worldwide in adult education (232–

235), English as a Second Language (236), worker and union education (237,238) and community development and health (239–241). Freirian dialogue becomes useful for marginalized peoples in examining the complexities of their disenfranchisement, within the various formal and informal systems. Women's positions of power, for example, may differ considerably between the public and private spheres. They may be an important income generator for the household, but have little say in household decision-making.

Two related concepts have been articulated by health professionals: community capacity and social capital. Community capacity is identified as containing ten dimensions, participation, support networks, sense of community and access to power (95), with processes and tools to measure capacity outcomes in development (38,44,93,242). Social capital, or the norms and social networks that facilitate coordination for mutual benefit, has captured the imagination of health professionals largely because of epidemiologic studies that have correlated the variables of trust, reciprocity and civic engagement to morbidity/mortality statistics (68,89–91). Both of these have overlapping definitions and may be used interchangeably, though social capital is more an attribute of communities rather than a strategy.

Two attributes of empowerment have been well articulated by the World Bank: the role of agency of marginalized communities to exercise choice and transform their lives, and the role of opportunity structure, the institutional, political, economic and governmental context that allows or inhibits actors to create effective action. Agency means that empowerment cannot be given to people or done to someone, but comes from processes where people empower themselves (2,225). Advocates or external change agents may catalyze actions or help create spaces for people to learn, but sustainability and empowerment occur only as people create their own momentum, gain their own skills, and advocate for their own changes. Their collective action to achieve their desired change is dependent on three stages, the social bases from which people start (political, economic, social, informational, moral), communities' individual skills and collective action capacities, and the results people are able to obtain (243). Health professionals have supported the concept of agency through recognizing the importance of working from strengths rather than from deficits to motivate community action (96).

As empowerment has gained credibility among governments and multilateral aid agencies, it becomes important not to revert to the belief that governments can provide empowerment as a service or another handout. Empowerment processes are distinct in their commitment to people's decision-making and engagement that may lead to challenges of powerful forces, including governmental institutions. Local, state and national governments, as major players in the opportunity structure, become primary focuses of empowerment strategies to force improved responsiveness to constituents, enhanced transparency, uncorrupted government and greater efficiency and more equitable distribution of resources and services to communities.

In sum, empowerment influences people's ability to act through collective participation by strengthening their organizational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains: psychological empowerment, household relations, enhanced social capital and cohesion, transformed institutions, greater access to resources, open governance and increasingly equitable community conditions.

Annex 2. Evaluation of empowerment

While understanding the role of empowerment interventions in reducing social exclusion and health disparities is a laudable goal, empowerment projects at the neighbourhood, village, municipal or national levels are difficult to evaluate. There is scant comparative literature and empowerment projects by their very nature are complex and do not easily fit into an experimental design (5,244–247). When neighbourhood groups or non-governmental agencies embrace broad missions to achieve community capacity and empowerment, there is usually no single programme to evaluate. Women's empowerment, for example, may be built into a micro-lending project combined with nutrition, immunization or family planning educational strategies. Outcomes therefore are only partially related to empowerment strategies. Expectations for individual health status changes may be unrealistic in short time frames, the empowerment projects may have insufficient inputs or skills to carry out tasks, or causal relationships may be too complex to uncover within a changing social environment. In addition, local or national morbidity/mortality surveillance systems are difficult to correlate to specific interventions.

The premise of much of empowerment intervention evaluations is similar to the premise of health promotion: local context matters in the implementation and in determination of results, dynamic processes are assumed, and participatory processes support continual evaluation and reformulation of strategies. As empowerment goals and activities purposefully change over time to meet the needs and priorities of the participating stakeholders, the intervention may be only partially evaluable (248) or even unevaluable using traditional methods (249). Community-based participatory research strategies have added to the participatory mix. Researchers now engage community participants not only in implementing interventions, but in the planning, development, and execution of evaluation and research strategies (42,43,250).

Finally, because empowerment processes take place on the psychological, organizational and community levels, and most often operate in conjunction with other intervention processes, outcomes also must be assumed within several domains and levels (251,252). Once a community may be identified as empowered or as producing results, however, maintenance of these conditions cannot be assumed. Empowerment outcomes are not static, may not be transferable to all issues, or may change over time as political or economic contexts shift; a community may be successful at preventing the installation of a hazardous waste facility, but unsuccessful at increasing funding for local schools the next year, or unsuccessful at changing norms about women's roles. This reinforces the need to continually evaluate changes within the opportunity structure, to evaluate the targets of change as well as changes in how communities exercise their agency for different goals.

Due to the complexity of both health promotion and empowerment, several international evaluation task forces have been convened to make recommendations, including the World Health Organization's Global Programme on Health Promotion Effectiveness (<http://www.who.int/hpr/ncp/hp.effectiveness.shtml>) and a Pan American Health Organization task force that has created a participatory evaluation handbook for healthy municipalities (253). In an incisive report on health promotion evaluation to policy makers, WHO published five conclusions: evaluation should be participatory, have adequate resources, examine both processes and outcomes, use a mix of methodologies and designs – rather than randomized control trials which “are in most cases inappropriate, misleading and unnecessarily expensive” – and further evaluation expertise in complex design should be fostered (254,255). The World Bank convened an interdisciplinary Measurement Workshop in February 2003, with two recent documents providing a structure for empowerment measurement and indicators (256,257).

To move along the pathway from multilevel empowerment outcomes to their influence on health and development outcomes, S.B. Rifkin has proposed the acronym CHOICE as representing six critical areas for measurement: capacity-building, human rights, organizational sustainability, institutional accountability, contribution and enabling environment (45). This approach builds from the four

facilitating processes proposed by the World Bank (64): people's access to information (part of their capacity building); their inclusion and participation in decisions (contribution); accountability of institutions and local organizational capacity (and sustainability), and adds the critically important areas of human rights and the enabling environment. Figure 1 combines the multiple empowerment dimensions and measures presented in this paper into one conceptual logic model for further exploration.

Figure 1: Pathways to empowerment

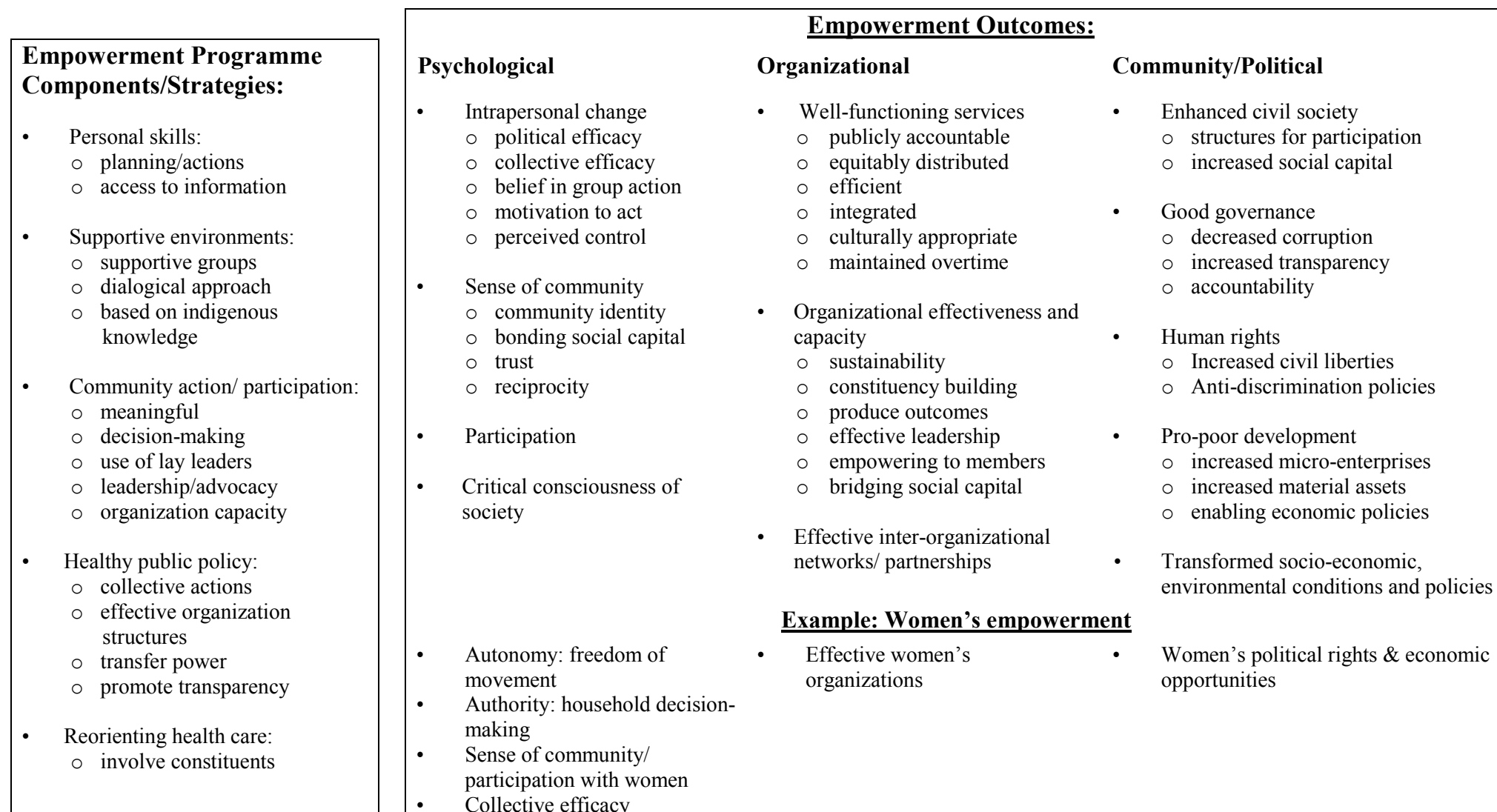
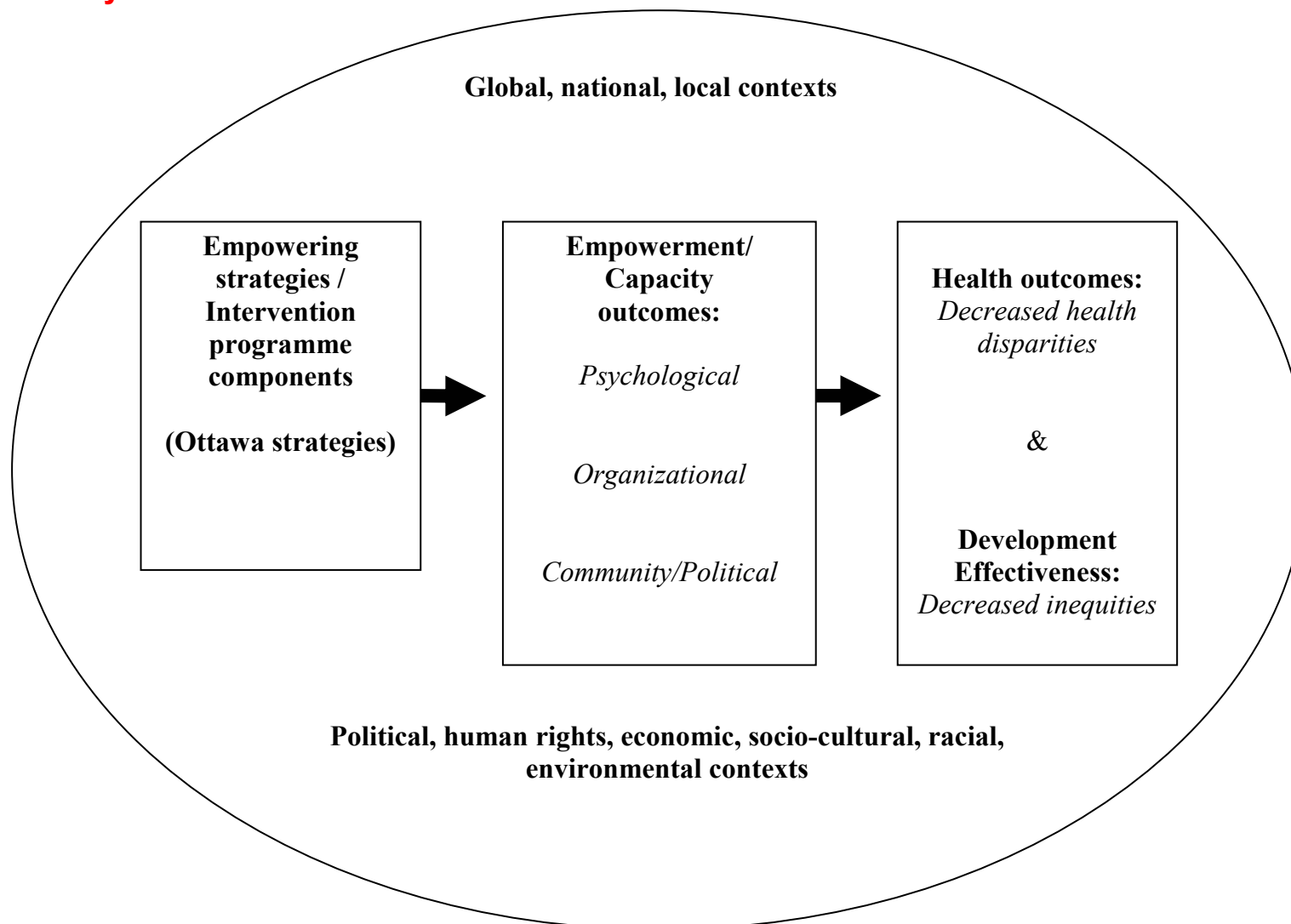


Figure 2: Pathways to health



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