Empowerment in the field of health promotion: recognizing challenges in working toward equity

Nicole S. Berry[1], Jill Murphy[1] and Larissa Coser[1]

https://journals.sagepub.com/doi/abs/10.1177/1757975914528725

Abstract: Over the last 25 years, the language of empowerment has been woven into the guiding missions and descriptions of institutions, funding and projects globally. Although theoretical understandings of empowerment within the domain of health promotion remain contentious, we have little idea of how a shift toward an empowerment agenda has affected the daily work of those in the field of health promotion. A systematic examination of the implementation of the empowerment agenda is important as it can help us understand how redistributive agendas are received within the multiple institutional contexts in which health promotion work is carried out. The goal of this study, therefore, was to try to understand the empowerment agenda within the context of everyday health promotion. We conducted semi-structured interviews with health promoters from a variety of geographical regions, institutional backgrounds, and job capacities. Essentially we found that empowerment remains conceptually dear to health promoters' understanding of their work, yet at the same time, mainstreaming empowerment is at odds with central trends and initiatives that govern this work. We argue that many of the stumbling blocks that have hindered this specific agenda are actually central stumbling blocks for the wider field of health promotion. We examine some of the barriers to implementing transformational change. Overcoming the primary limitations uncovered in this exploration of empowerment is actually crucial to progressive work in health promotion in general, particularly work that would seek to lessen inequities. (Global Health Promotion, 2014; 21(4): 35–43)

Keywords: empowerment, power, equity, social justice, health promotion

Introduction

Last year marked 25 years since the adoption of the Ottawa Charter and the beginning of a 'new health promotion'. A central part of the transition to a post-Ottawa Charter world was the ascendancy of the concept of empowerment as central to the work of health promoters. Thinking through empowerment has certainly created an indelible theoretical mark in the field, although little consensus has been reached on fundamental questions such as whether empowerment is a process, an outcome, or both, what empowerment might mean, and whether or not an empowerment approach is efficacious or even desirable (particularly vis-à-vis alternative, more traditional health promotion approaches) (1–4).

While theoretical understandings of empowerment remain contentious, we also have little idea about how the empowerment agenda has affected the daily work of those in the field of health promotion. Since the Ottawa Charter, empowerment has been woven into the guiding missions and descriptions of institutions, funding and projects globally (5). Yet the brief glimpses that we do have of how the

1. Faculty of Health Sciences, Simon Fraser University, Canada.

Correspondence to: Nicole S. Berry, Faculty of Health Sciences, Simon Fraser University, 8888 University Drive, Burnaby, British Columbia, V5A 4Z2, Canada. Email: nicole_berry@sfu.ca

(This manuscript was submitted on 14 October 2012. Following blind peer review, it was accepted for publication on 10 December 2013)

Global Health Promotion 1757-9759; Vol 21(4): 35–43; 528725 DOI: 10.1177/1757975914528725 http://ghp.sagepub.com

Table 1. Characteristics of interviewees.

Type of organization					*Job responsibility*			*Geography*	
IO	*Gov*	*MoH*	*NGO*	*Univ*	*Policy*	*Design*	*Delivery*	*LMIC*	*HIC*
2	2	7	5	11	8	18	16	17	7

IO: international organization; Gov: government employee (non Ministry of Health); MoH: Ministry of Health; NGO: non-governmental organization; LMIC: low or middle income country; HIC: high income country.
Note. Some interviewees discussed more than one job experience, so numbers of each category sometimes exceed 22.

empowerment agenda has impacted practice in the field of health promotion tend to be individual case studies of process, or evaluations that attempt to address the question of efficacy (6–9). We have few reflexive interrogations that can help us understand what this shift has meant to practitioners, or how it has shaped everyday work in the field of health promotion (10).

There are a number of reasons why health promoters should be interested in a more systematic, reflexive examination of the mark of the empowerment agenda on everyday work. First and foremost, we have plenty of evidence that what planners intend and what might happen on the ground differ vastly, especially when garnering participation is involved (11,12). So official accounts and policies might not prepare us to characterize what is actually happening on the ground (13). In addition, a better empirical understanding of how the empowerment agenda has shaped everyday practices is particularly important to further our understanding of how health promotion can work on the health inequities that remain at the root of poor health outcomes in many communities. Working toward empowerment to reduce these inequities inevitably means addressing power relations and resource distribution. Therefore, examining how empowerment has hit the ground, so to speak, helps us understand how redistributive agendas are received within the multiple institutional contexts in which health promotion work is carried out.

The goal of this study is to try to understand the empowerment agenda within the context of everyday practice. Below we outline prominent points that resonated through our conversations about what the empowerment agenda has meant to practitioners in the field from multiple domains. Essentially we find that empowerment remains conceptually dear to health promoters' understanding of their work and goals, yet at the same time, the mainstreaming of the concept is at odds with central trends and initiatives that govern this work. We then go on to discuss how the primary limitations uncovered in this exploration of empowerment are actually crucial to progressive work in health promotion in general, particularly work that would seek to lessen inequities.

Methods

Health promotion is a diverse field, and to understand how the empowerment agenda may have impacted practice, we needed information from a variety of geographical and professional settings. Taking advantage of the 20th International Union for Health Promotion and Education (IUHPE) conference (July 2010 in Geneva) to recruit participants essentially made this project feasible, as we were able to reach a heterogeneous group of interviewees over three short days (see Table 1). To recruit participants, we first emailed a few presenters whose contact information was searchable on the web. At the conference itself, we made a special effort to track down and invite presenters whose title included the word 'empowerment'. Yet, the vast majority of our interview participants were randomly approached on the mezzanine onsite and asked to participate. Interviews were semi-structured (14); we began by inviting the interviewee to tell us about their work experience in health promotion, then reflect on the role of empowerment in their current workplace, and finally explore their own opinions on empowerment and how it has shaped practice. Most interviews were conducted at the meeting in English, but we also interviewed in French, Spanish, and Portuguese (interviewers were at least functionally fluent if not native speakers of these languages). Three interviewees asked to be contacted after the conference, and were followed up over

Skype. In total, we interviewed 22 different people ranging from all major areas of the world (Americas, Africa, Europe, Asia, Western Pacific), who worked for different types of organizations, as well as in different capacities (policy making, program design, and program delivery). All interviews, which lasted from about 35–90 minutes, were recorded, translated where applicable, transcribed and entered in the Weft QDA qualitative software package.

While using the IUHPE conference for recruitment was an excellent opportunity, it also created certain limits. Due to high travel costs, only health promoters with the economic means to travel to an international conference in Geneva were interviewed, potentially excluding more marginalized workers or groups from participating in the research. Academics were also well represented at the conference and, therefore, in this study. Because participating in a conference can be an exciting experience for many, interviewees may have been overly enthusiastic or perhaps more optimistic than normal. As discussed below, understandings of empowerment may be significantly shaped by cultural backgrounds and, therefore, our sample may over-represent some world views or understandings of empowerment, while excluding others. In addition, shared insight into participants' real-life context was missed by interviewing at the conference, perhaps limiting our ability as researchers to accurately interpret or understand interviewees.

After the conference, two team members who conducted the interviews drew on their knowledge of the goals of the study, the interview questionnaire, and their experiences as interviewers to independently draft a preliminary code book that contained both descriptive labels (e.g. type of organization within which participant worked) and codes and subcodes they felt emerged during the interviews. They subsequently met to process and merge their draft codes, which became the preliminary code book. The transcripts were coded independently by two team members—one of whom had not conducted the interviews. These coders applied the preliminary code book to four interviews, adding new codes as needed, then met to compare and standardize both coding and code books (15). Next, they independently finished coding the entire corpus. Ultimately, there were no major inconsistencies concerning themes or conclusions. To focus this article, we chose the main emergent themes that not only cross-cut the data, but that also spoke to contemporary issues in health promotion. The final article was outlined by the first author, and authors collaborated on writing different sections of the paper.

This study has certainly been shaped by our main assumption that empowerment has been an important part of the diverse field of health promotion. This assumption is deeply intertwined with the idea that we could have meaningful conversations with a diversity of health promoters about how empowerment shaped their daily work. While no one refused to be interviewed due to empowerment's lack of relevance, our focus could certainly magnify the apparent importance of the concept to the average participant's daily work life.

Empowerment: inspiring yet problematic

Given the disagreements over how to define empowerment and the diversity of our interviewees, we started our interviews by asking participants to define the concept. The post-Ottawa idea that empowerment is at the heart of and embodies the core values of health promotion resonated with what we heard. One participant's definition of what it means to be empowered captured many of the common themes that emerged:

> …[being] able to have an impact on your environment, to be able to make positive change, to defend what you feel is important, to promote peace and health and well-being in the community.

Empowerment as a concept was largely seen as a powerful catalyst for positive change, and participants talked about the importance of empowerment in their own professional settings as well as in relation to the work they did. Given the positive way in which interviewees related to the empowerment concept, we were surprised that participants were simultaneously reluctant to use the term in reference to their own work. For example, a number of issues came up with using the word 'empowerment' within bureaucratic institutions. In contexts with a strong top-down tradition in governance, interviewees discussed the lack of interest or awareness about empowerment in government. Many interviewees discussed the challenges of having to 'translate' the term on the fly for bureaucrats.

In addition, bureaucrats and funders often perceived empowerment to be soft ('touchy-feely') and therefore not taken seriously as technical or scientific language.

A number of issues that made health promoters reluctant to use the term empowerment were concerned with what the word actually meant. Many participants stated that the term is too broad and too 'opaque', making it difficult to find a common understanding on which to base a program or intervention. Other interviewees described it as a 'buzz word' that has lost meaning through overuse, transforming it into jargon. Interviewees stated that using the term does not necessarily mean that empowerment will take place. As one participant from Indonesia stated: 'empowerment is really easy to say but really difficult to do'. Many participants who discussed drawing on the concept as a positive aspect of their work intentionally avoid specifically using the word. The following exerpt was typical of that theme:

Participant: Sometimes in these discussions we don't even use the word empowerment.
Interviewer: Okay, and what would you use?
Participant: Well, we'll talk about people making decisions that can influence their lives and give them control. Simple words.

Similar to the challenges of having to 'translate' the term for bureaucrats and funders, the term empowerment was frequently perceived as being too technical or tied to the academic domain for use with communities or when working with multiple stakeholders with diverse expertise. One interviewee summed up well the problems of using the word:

> If one gets caught up in a semantic argument, you can't get out. You start to create definitions that are circular, and it doesn't generate action. When you do practice, it's not as conflictual, because it is something that you live and feel and that you can value and measure and see how you feel and how people change. Nevertheless, the theoretical part is very conflictual. It generates a ton of conversations that don't get you anywhere.

To use the term meant that a significant amount of time must be dedicated to finding a common understanding. For some, the perception that the term empowerment was academic jargon meant that using it risked alienating communities and the term was therefore perceived as anathema to building trust among diverse partners involved in health promotion.

Of great relevance to health promotion globally is the fact that the word 'empowerment' does not translate easily into many languages and cultures. As Erzinger (16) describes, the challenge of translating a word like empowerment into another language is not simply finding an equivalent word, but in capturing complex concepts that may have differing cultural meanings and applications. For example, the concept of the individual and individual agency—fundamental to how a person in an English-speaking high income country (HIC) might understand empowerment—differs across many cultures. Therefore, while the term 'empowerment' is contested even among native English speakers, many interview participants from non-English-speaking countries described the additional challenge of understanding and putting into practice a term that is not only adapted from English but also does not have a clear conceptual referent in many languages and cultures.

Empowerment as a transformation agenda

> I want to laugh when I hear, when I hear that word, 'empowerment'—to give the power to the people. You know, this life is not like that…

While specific definitions of empowerment varied, the idea that empowerment includes a shift in power structures was a central concept that underwrote almost all talk. Interviewees related empowerment agendas to relations of power in multiple domains. At the highest levels, participants referred to global power inequities among and between HICs and LMICs (low middle income countries) that resulted in a lack of appetite and ability to do empowerment work in LMICs, as well as an arrogance that neutered acknowledgment that Southern countries could provide innovative solutions to health problems, even ones that could be taken up in the global North.

Participants also talked about empowerment as potentially shifting power dynamics between a government and its citizens. The issue of power inequities along gender lines came up both with reference to society at large—for example, women's abilities to negotiate rights with husbands—and within governance and academia, where interviewees discussed professional females' lack of voice and credibility in comparison to male counterparts. Class inequities between those of upper and middle classes versus those in poverty was a continual theme. Finally, the privileged position of biomedicine to dictate the direction of resources within governments, projects, and academia was also cited as a power imbalance to be shifted. Challenging power structures in one domain or level could create a 'chain reaction', encouraging people to look at other domains or levels where they need to take action to shift power dynamics.

As the quote that begins this section belies, a number of interviewees opined that they steer away from framing their work as empowerment because, at the most basic level, promoting empowerment can be interpreted as asking those with power to agree to give some of it up. The literature is certainly riddled with experiences of projects that intentionally or tacitly adopted a mandate predicated on the redistribution of power, but essentially failed as there was never a high-level political process in place to support this redistribution (17). As one interviewee stated, ideologically and culturally people in power have been socialized 'to resist empowering those people out there who are different and…who are impolite and don't know how to deal with meetings and who are unkempt and not educated but clever'. However, participants also brought up the fact that while working for the redistribution of power is difficult in all circumstances, working to enfranchise those who had the least power was doubly so. Many interviewees felt those with power came up with 'all sorts of justifications' for why those who were enfranchised should have advantages or why those who were disenfranchised could not be accorded any. Ultimately many felt that the crux of the situation was that those in power were 'instinctually' against anything that would 'diminish their own power'. As long as there was no agreement or mandate from those in power to redistribute it, empowerment as an agenda would remain embattled.

Yet a few interviewees pushed aside this idea that competition for power was central to transformations in power; instead, these interviewees articulated the centrality of dialogue to what they conceived of as an empowerment process. These health promoters conceived of themselves more as facilitators whose job was to enter into dialogue with existing parties and 'help them organize to make them able to analyze their own situation'. Through examples these interviewees made it clear that the empowerment process hinged on working with people (be it disenfranchised community members, women, governments, communities, etc.) and that these people can choose to do differently the things that they do. Thus, in this model, empowerment hinged on using resources that were already available, not commandeering permission to co-opt others' resources or demanding a redistribution of power. Interviewees provided a number of examples of people choosing 'the best solution for them' to successfully resolve issues such as husbands that sleep around, genital cutting, and access to health care for the poorest in a community.

The challenge of hope

There was a strong consensus among interviewees that recent history had created environments that made it difficult to work with disenfranchised communities on empowerment. The basis of this narrative was that structures of power are corrupt in multiple ways. It is therefore hard for health promoters to garner involvement from people who have experienced years of daily abuse, for no one can work toward empowerment if they do not have hope that things can or should change.

Many interviewees working in LMICs described systems of patronage relations that supported the interests of the rich. In a patronage system, resources are aggregated by an individual or a group of individuals, who then distribute these resources to those who curry favor with the patron. At the most local levels, interviewees described how patron relationships organized activities and loyalties. For many, it was easier to affiliate with a patron where pay-offs were given straight away than to work toward empowerment. In addition, the entrenchment of patronage stood as a constant reminder that many were willing to support the interests of the patron if it got them somewhere,

while there was little to no evidence of those willing to support the interests of the poor. Development activity itself was described as part of the patronage system. Poor people had decades of learning that development was a foreign activity—that is inspired by and for others. In this case, rich countries and non-governmental organizations (NGOs) were seen as patrons who set specific criteria for their monetary support. There were always middle men willing to work for their interest. As in the past, poor communities were never equal or for that matter important partners in this process, and it was difficult for health promoters to garner the hope and belief that somehow empowerment-based projects could or would be different.

Yet even graver than the effects of the patronage system, many interviewees talked about the effects of systematic oppression that created not only hopelessness but a fundamental lack of confidence in a community's ability to provoke structural change. As an agenda, empowerment not only demands participation, but a belief that one can create and is deserving of the changes that one seeks. Many interviewees described working on empowerment with oppressed and disenfranchised people as difficult because you are essentially asking people to stop believing what they have been told about themselves, about their place in this world and how they have experienced the world to date. One participant described the situation like this:

> …the difficulty with the people we work with is the lack of confidence that people have in themselves and the total lack of hope. They are people who have gone through a systematic process of discrimination and you have to work a lot to help them recover, so that they can regain their capacity.

While the theme concerning a lack of confidence was most predominant in interviewees who worked in LMICs, it also surfaced in an interview with a health promoter who worked with indigenous people in a HIC. Working with these populations to find their confidence and hope was viewed just as essential as any official health-related project in itself.

The challenge of empowerment in a results-based environment

A central challenge to translating empowerment into practice is the tension between the nature of empowerment itself and the current environment of health promotion. Dominant structures, such as funders and government agencies, increasingly required health promotion programs to demonstrate direct cause and effect related to predetermined indicators. Using tools such as logic models, funding recipients had to demonstrate the impact of their interventions to ensure accountability. The increasing importance of evidence-based monitoring and evaluation in the field of health promotion (18,19), the preference for short-term funding and top-down organizational structures were identified by many interviewees as inconsistent with long-term processes such as empowerment.

Many interview participants saw funders' monitoring and evaluation requirements as problematic to their work promoting empowerment. Primarily they described a gap in the evidence base about best practices for empowerment, such as the lack of appropriate indicators on which to base program evaluations. As one participant described:

> …you get stuck with indicators coming from epidemiologists, coming from economists, which are much more quantitative and the qualitative side of things gets left out.

Interviewees also traced the root of this gap in knowledge about evaluation to an academic environment that continues to prioritize quantitative and biomedical research, such as clinical trials. Participants called for increased support for qualitative research to identify best practices for empowerment in health promotion, followed by effective dissemination of research results. Yet many felt that logic models and universally applied indicators would likely fail to capture the true, nuanced, impact of health promotion programs on empowerment. The contention that empowerment can only be understood in relation to particular contexts as well as the conceptualization of empowerment as a non-linear process rather than an outcome were noted as potential barriers to ever fitting empowerment into current results-based models.

The issue of time posed a number of challenges for applying empowerment in health promotion (20). While funding cycles generally follow a limited number of months or years, the process of empowerment can take a substantial amount of time. One participant summarized her frustration:

> …[donors] want to empower people to make changes that took [rich countries] hundreds of years to do and they wanna a five year funding cycle. It's not real.

Empowerment as an objective, according to interview participants, could not authentically be written into a program time-line. Many participants also argued that sustainable change should be an integral part of successful empowerment in health promotion. A number of elements that are essential to achieving sustainability, including capacity development and trust, were not easily achieved within the limited time frame for which many programs received support. In addition, setting out to achieve sustainable empowerment through short-term programs could be counterintuitive, as the brief availability of resources, both human and financial, could build expectations, create confusion, and encourage dependency. All these negative consequences could hinder trust building between stakeholders, the development of individual and community capacity, and, ultimately, sustainability that is essential for empowerment.

As indicated earlier, interviewees felt that empowerment must involve change at the structural level, and the organizations that make policy and fund and implement health promotion initiatives were viewed as examples of structures that needed to change. Yet the dominant culture of many organizations remained top-down. In reality, this top-down approach led to a significant disconnect between organizations and communities, including the implementation of programs that did not reflect community priorities and sustained patronage systems. Referring to this challenge, one respondent stated:

> So policy at the highest level is brought down, it appears alien and people are not receptive to it.

In sum, such programming could endanger community enthusiasm to collaborate with health promoters on empowerment.

Interviewees were quite clear that the current organizational structures in which health promotion programs were developed and implemented were designed in a way that seemed at odds with the principles of empowerment. This means that the inclusion and implementation of a meaningful empowerment agenda in health promotion was extremely difficult.

Reflection

Although the IUHPE conference may provide a clearly bounded venue full of health promoters, health promotion as an activity is not so clearly bounded. In designing this study, we thought that we had circumvented the thorny issue of defining health promotion and health promoters by allowing interviewees to establish these referents themselves. Nevertheless, when reflecting upon our findings, we were struck by how they resonated with larger issues facing the fields of global health governance and North/South development. Clearly, health promotion remains positioned within larger institutions, trends, and systems. Partly, this must be due to the fact that outside of a few HICs, training for health promotion is frequently unavailable (21,22), and those who are responsible for the everyday work are necessarily drawn in from other sectors. However, even where interviewees worked in units or programs that were specifically entitled 'health promotion', these units and programs were governed by higher logics and rules (e.g. of government health ministries or development funders). In addition, many of the interviewees contextualized health promotion within a framework of responding to global agendas, such as the Millennium Development Goals and responding to social determinants of health, further muddling the idea that health promotion could be addressed outside of these bounds.

Perhaps for these reasons, our findings from this study both strongly resonate with other studies that identify major challenges to improving health globally and seem to define larger challenges facing the field of health promotion at this juncture. Certainly these data speak to central tensions between vertical and horizontal programming that currently plague the field of global health (as well as health promotion) (23,24). Yet, interviewees were also able to expand on this tension by identifying the real effects that years of either failure to respond

to the needs of citizens, or the outright denials of human rights, has created. The fatigue, the deleterious environment, and lack of hope palpable in many disenfranchised communities are central stumbling blocks for any attempts to improve health outcomes. Indeed it is difficult to conceive of how an empowerment agenda or any other equity agenda can be pushed forward without seriously taking into account the need to distribute basic socio-economic and political rights. Thus, it is equally difficult to conceive how those who hold decision-making capacity would be able to promulgate change while protecting their own interests. These interviewees clarified that we need not think of the interests of the powerful only in abstract terms of political economy, but rather can find them entrenched in everyday accountability mechanisms that so clearly characterize today's program environment.

Conclusion

It is difficult to specifically extricate what the empowerment agenda has meant to everyday practice in the field of health promotion from the wider context in which health promotion presently finds itself. While it would seem that the intellectual enthusiasm for codifying the role of empowerment in the field has waned (25), the health promoters we interviewed remain inspired by the ideal that empowerment represents. Given this context, perhaps the inspiration alone that health promoters draw from the idea of empowerment should not be overlooked and may be a topic for further exploration and research. Nevertheless, health promoters' thinking about the empowerment agenda vis-à-vis their own everyday work has provided an illustrative insight into some of the challenges that the field faces. As the mandate to change health outcomes veers toward addressing social determinants of health, particularly to decrease health disparities, identifying the actual stumbling blocks that health professionals will face is imperative. Political bureaucracies and patronage systems, as well as other ostensibly benign trends, such as results-based management, can all undermine genuine attempts to create sustainable changes in vulnerable communities.

Conflict of interest statement

None declared.

Funding

This research was funded through a small grant received from the SFU/SSHRC Institutional Grants Committee.

References

1. Laverack G. Improving health outcomes through community empowerment: a review of the literature. J Health Popul Nutr. 2006; 24: 113–120.
2. Wallerstein N. What is the Evidence on Effectiveness of Empowerment to Improve Health? Copenhagen: WHO Regional Office for Europe; 2006.
3. Braunack-Mayer A, Louise J. The ethics of Community Empowerment: tensions in health promotion theory and practice. Promot Educ. 2008; 15: 5–8.
4. Simons-Morton BG, Crump AD. Empowerment: the process and the outcome. Health Educ Behav. 1996; 23: 290–292.
5. Capone V, Petrillo G. Health Promotion in international documents: strengths and weaknesses from the perspective of community empowerment. J Community Appl Soc Psychol. 2011; 23: 98–114.
6. Laverack G, Whipple A. The sirens' song of empowerment: a case study of health promotion and the New Zealand Prostitutes Collective. Global Health Promot. 2010; 17: 33–38.
7. Wilson N, Dasho S, Martin AC, Wallerstein N, Wang CC, Minkler M. Engaging young adolescents in social action through Photovoice - the Youth Empowerment Strategies (YES!) project. J Early Adoles. 2007; 27: 241–261.
8. Gómez CA, Hernández M, Faigeles B. Sex in the New World: an empowerment model for HIV prevention in Latina immigrant women. Health Educ Behav. 1999; 26: 200–212.
9. Yoo S, Butler J, Elias TI, Goodman RM. The 6-Step Model for community empowerment: revisited in public housing communities for low-income senior citizens. Health Promot Pract. 2009; 10: 262–275.
10. Jacobs G. Take control or lean back? Health Promot Pract. 2011; 12: 94.
11. Busza J. Participatory research in constrained settings. Action Research. 2004; 2: 191–208.
12. Campbell C, Mzaidume Z. Grassroots participation, peer education, and HIV prevention by sex workers in South Africa. Am J Public Health. 2001; 91: 1978–1986.
13. Wallerstein N. Empowerment to reduce health disparities. Scand J Publ Health. 2002; 30: 72–77.
14. Bernard HR, ebrary Inc. Research Methods in Anthropology Qualitative and Quantitative Approaches. Lanham, MD: AltaMira; 2011.
15. Friese S. Qualitative Data Analysis with ATLAS. ti. London: SAGE Publications Limited; 2012.
16. Erzinger S. Empowerment in Spanish: Words can get in the way. Health Educ Behav. 1994; 21: 417–419.
17. Heenan D. A partnership approach to health promotion: a case study from Northern Ireland. Health Promot Int. 2004; 19: 105–113.

18. Dunne A, Scriven A, Furlong C. Funding linked to evidence: what future for health promotion? Perspectives in Public Health. 2012; 132: 109–110.
19. Juneau C-E, Jones CM, McQueen DV, Potvin L. Evidence-based health promotion: an emerging field. Global Health Promot. 2011; 18: 79–89.
20. Batten L, Holdaway M. The contradictory effects of timelines on community participation in a health promotion programme. Health Promot Int. 2011; 26: 330–337.
21. Barry M. Capacity building for the future of health promotion. Promot Educ. 2008; 15: 56–58.
22. Howze EH, Auld ME, Woodhouse LD, Gershick J, Livingood WC. Building health promotion capacity in developing countries: strategies from 60 years of experience in the United States. Health Educ Behav. 2009; 36: 464–475.
23. Behague DP, Storeng KT. Collapsing the vertical-horizontal divide: an ethnographic study of evidence-based policymaking in maternal health. Am J Publ Health. 2008; 98: 644–649.
24. Ooms G, Van Damme W, Baker B, Zeitz P, Schrecker T. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems? Globalization and Health. 2008; 4: 6.
25. Woodall JR, Warwick-Booth L, Cross R. Has empowerment lost its power? Health Educ Res. 2012; 27: 742–745.