Theory in Action: Public Health and Community Power Building for Health Equity

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ABSTRACT

Context: Within the field of public health, there is growing awareness of how complex social conditions shape health outcomes and the role that power plays in driving health inequities. Despite public health frameworks lifting up the need to tackle power imbalances to advance equity, there is little guidance on how to accomplish this as an integral part of health promotion.

Objective: This article addresses the need for public health professionals to better understand power and identifies opportunities for shifting power to achieve more equitable outcomes. First, it defines power and community power building. Next, it reviews a pragmatic theoretical framework that organizes power into 3 faces: (1) exercising influence in formal decision-making processes; (2) organizing the decision-making environment; and (3) shaping worldviews about social issues. Finally, it connects each face of power to community power-building practices using concrete examples.

Implementation: This article highlights real-world case examples to demonstrate how theory translates to action by describing how public health practitioners in government, academic, and nonprofit settings incorporate the 3 faces of power into their work. The case examples illustrate how public health organizations and practitioners can partner with those most impacted by inequities to help shape decision making, agenda setting, and worldviews to influence policy and practice toward more equitable outcomes.

Discussion: The public health field can learn from and build on these innovative examples to establish new practices, scale up promising approaches, and evaluate what works to shift power for the greater good.

KEY WORDS: community power building, health equity, public health practice, social determinants of health

Communities today are navigating layered effects of the COVID-19 pandemic and its variable impacts across race and place, renewed social unrest and struggles over civic exclusion, heightened debates about the role of government, and insufficient resourcing of essential public agencies. The field of public health—those working to "collectively assure the conditions in which people can be healthy"[1(p1)]—is increasingly and acutely aware of how these complex conditions influence the ability of all communities to reach their full health potential. The field is reorienting around social and structural determinants of health and has deepened understanding of health inequities, or systematic and avoidable differences in health.[2] There is growing acknowledgment that factors driving health inequities and complex social conditions are intertwined.

Significant public health bodies have recognized power as a key driver of health outcomes and inequities.[2-4] For example, in 2008, the Commission on Social Determinants of Health called for action to "tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally."[2(p2)] In other words, power imbalances manifest as social injustices across multiple determinants of health, including housing, education, employment, and criminal justice, and thereby impact health and equity outcomes. These injustices can lead to the complex social conditions we are witnessing today.[5]

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This moment, therefore, presents unique opportunities for public health organizations and professionals to practice in new ways by focusing on shifting power.[6] Despite public health frameworks lifting up the need to tackle distributions of power (no small task), there is little guidance on how to accomplish this as an integral part of health promotion. One promising approach is building community power.[5]

In this article, we address this need for public health professionals to better understand power and identify opportunities for action. First, we define power and community power building. Next, we review a pragmatic theoretical framework that organizes power into 3 faces, described in the Table later.[7,8] Finally, we connect each face of power to community power-building practices using concrete case examples. These examples of theory in action illustrate how public health practitioners in government, academic, and nonprofit settings incorporate the 3 faces of power into their work, alongside those most impacted by inequities.

Power and Health Equity

Power can be defined as the capacity to act to individually and collectively shape our world.[9] We use the term *community power* to mean "the ability of communities most impacted by structural inequity to develop, sustain, and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity."[5(p6)]

Power is the advantage held by those at the top of hierarchies based on race, class, gender, sexual orientation, religion, ability, geography, and other characteristics. Power imbalances underlie structures of oppression, such as systemic racism, and lead to inequities. Many have written about ways of understanding power,[10] and the relationship between equity and power has long been recognized by public health thought leaders.[4,6,11-14] Public health literature continues to define terms and concepts related to power,[10] develop theory and frameworks for understanding it,[14,15] and explore ways to measure it.[4] Major health funders in the United States now have initiatives focused on power.[5,16] However, *how* to collectively build community power to advance health equity is still an emerging focus in the public health field.[17]

There are many potential approaches to building and shifting power; public health organizations and practitioners can contribute by sharing the power they have directly over public health decisions, supporting community power building, and working to limit power that is wielded to maintain or advance inequitable policies and practices.

In this article, we introduce the "Three Faces of Power" framework[7] because it provides a pragmatic lens that both illuminates conditions and instruments of power and points to interventions that can address power imbalances. Descriptions of each face of power and associated actions to build community power are provided in the Table.[7,8]

Although the practice of shifting power might be novel within the public health field, community-organizing movements have long centered their work around building power to address inequities.[4] Some groups organize around the 3 faces of power, but all generally bring together those most impacted by an issue to identify shared concerns, develop a critical understanding of the issue, and mobilize around common goals to influence decision making.[5,12] This approach to community power building resonates with public health frameworks, given its developmental, collaborative nature, and opportunities for strategic partnership. Furthermore, building community power is an outcome in and of itself that can advance health and equity.[18]

Later, we describe how public health organizations and practitioners can shift and build community power according to each of the 3 faces of power. We present case examples of public health interventions and outcomes within government, academic, and nonprofit settings. Although these examples have not been formally or fully evaluated, we believe that it is valuable to highlight innovative approaches for addressing power imbalances that public health practitioners can apply in different roles and contexts. We also acknowledge that the faces of power, while separated into dimensions, are dynamic and interrelated.[7] These interventions typically address multiple faces of power but are organized here according to the primary intent of the intervention.

The first face of power: public health interventions in decision making

Public health professionals regularly make decisions about their own initiatives and budgets. They also use data, research, communications, and advocacy to educate policy makers and influence other decisions. In doing so, they employ the first, most visible face of power. These actions may or may not advance equity and have historically advanced inequity at times.[19]

To shift power in equitable ways, public health organizations and practitioners can share decision-making power with those facing inequities on issues that public health directly controls. They can also

TABLE
The 3 Faces of Power and Associated Actions to Build Community Power

Face of Power	Description[7]	Actions That Can Be Used to Build Community Power[8]
1: Visible	Exercising influence in the political or public arena and among formal decision-making bodies to achieve a particular outcome.	Organizing people and resources to influence public or formal decision-making processes through direct involvement and action, such as enacting administrative policy, designing and funding programs, voting on an issue, influencing budget decisions, lobbying decision makers, or electing public officials to be decision makers.
2: Hidden	Organizing the decision-making environment, including who can access decision making and what issues are being considered by decision-making bodies.	Building durable, long-term civic infrastructure to affect the conditions that precede decision making, such as developing and supporting networks of organizations that are aligned around shared goals, and that can shape public agendas and resource distribution.
3: Invisible	Shaping information, beliefs, and worldviews about social issues.	Lifting up worldviews, values, and forms of behavior by shaping public narratives—collections of deeply rooted stories in our collective consciousness that transmit values and ideas about how the world works. Government, education, research, media, religious, political, and social institutions do this by helping people make meaning of events and happenings in the world.

share funding and resources and when possible shift control of budgets to community groups working to build power. To address social determinants that are beyond the purview of public health, practitioners can work alongside those facing inequities to influence or intervene in public decision-making processes. This involves authentically engaging community members to understand and address their priorities, being able to analyze power dynamics, identifying and connecting with existing power-building efforts, developing partnerships with community leaders and power-building organizations, and possibly becoming personally activated in social change. The following case examples demonstrate how public health professionals can exercise the first face of power by supporting community power-building efforts.

- The Santa Barbara County Public Health Department (SBCPHD) in California has sustained a deep partnership with Central Coast Alliance United for a Sustainable Economy (CAUSE), a local organizing group with working class and immigrant members. The partnership grew from SBCPHD and CAUSE entering into a joint project with shared funding to advance CAUSE's efforts to ensure farmworkers had access to toilets while working in agricultural fields. Because of this relationship, at the start of the COVID-19 pandemic, CAUSE helped SBCPHD quickly understand issues farmworkers faced including those resulting from congregate living situations. With CAUSE's help, the county gained support for and issued a first-of-its-kind health officer order, supported by farmworkers, which improved the detection of cases among farmworkers, reporting systems, and isolation of farmworkers when symptomatic.[20]
- The California Work & Family Coalition (CWFC), a statewide alliance of community organizations, unions, nonprofits, and individuals, initiated a partnership with Human Impact Partners (HIP), a public health nonprofit, and the San Francisco Department of Public Health (SFDPH) to conduct a health impact assessment of a proposed state paid sick leave policy.[21] Using the findings, HIP and SFDPH worked with CWFC to influence the legislative process, including by testifying at legislative hearings. Human Impact Partners also conducted health impact assessments on paid sick leave proposals in other states, partnering with similar coalitions, and used the reports to draw media attention to the issue and advocate that elected officials pass legislation. These efforts contributed to paid sick leave policies being passed in jurisdictions across the country.
- WISDOM, a congregation-based community organizing group, partnered with University of Wisconsin and HIP researchers to obtain grant funding and then subcontracted with these researchers to conduct a health impact assessment examining Treatment Alternative Diversion (TAD) programs in Wisconsin. The effort was led by power-building organizations, with extensive multisector participation, and contributed to a statewide campaign for criminal justice reform. The campaign demonstrated how crimes are often rooted in issues such as substance abuse and unmet mental health needs and should be addressed through a public health lens. The campaign successfully influenced state policy

makers to shift community justice reinvestments to include better mental health options and increased budget allocations for TAD programs by 150%.[22]

The second face of power: public health interventions in agenda setting

The second face of power, sometimes hidden from public view, involves the ability to build networks and infrastructure that shape the conditions preceding formal decision making, such as setting public agendas and determining where to focus resources. Public health organizations and practitioners often influence the second face of power through their roles as conveners and facilitators of community networks. For instance, public health departments frequently convene coalitions to identify and address community priorities through creating Community Health Assessments and Community Health Improvement Plans. These coalitions typically develop interventions that advance a proactive agenda and may introduce new policy concepts.

Agenda-setting activities can explicitly focus on equity and support community power building. For example, public health organizations can help strengthen existing community organizing and civic participation infrastructure by partnering with organizing groups, centering the voices of community members in coalition decision making, and shifting resources to organizing groups. Furthermore, public health practitioners can organize themselves—in their work capacity or otherwise—and use their collective voice in allyship with those facing inequities to advance an equity agenda. The case examples below illustrate these types of interventions.

- Public Health Awakened (PHA), "a national network of public health professionals organizing for health, equity, and justice," partners with social justice movements to take collective action on social determinants of health including housing, immigration, and incarceration. This relatively new infrastructure is working to not only impact decisions (the first face of power) but also change what is on the political agenda (the second face). In response to COVID-19, for example, PHA worked with others to advocate that the federal government put "stronger workplace protections; access to safe, affordable housing; decarceration of jails, prisons, and detention centers; and expanded vaccine access" on its agenda.[23]
- Through HIP's Power-building Partnerships for Health, local health departments in multiple sites have partnered with community organizing groups in their counties to develop trusting relationships and take actions to support a campaign identified by the organizing group and its members. Funding is made available for each campaign and decisions on what actions to pursue and how to spend funds are determined jointly by the partners. These partnerships have helped bring new issues to decision-making agendas, such as housing for formerly incarcerated people, which have led to local policy changes.[24]
- The criminal justice reform campaign in Wisconsin, described previously, brought new issues to the legislative agenda such as consideration of mental health needs in funding decisions. Importantly, the process also established state and local networks of public health, criminal justice, and organizing partners that provide lasting infrastructure to influence public agendas around criminal justice reform. Local committees and coalitions shaping policy implementation now more frequently include representation from public health professionals and people who have been formerly incarcerated. Statewide public health entities formed partnerships with community organizers who have been formerly incarcerated to participate in state policy conversations around public health and safety.

The third face of power: public health interventions in shaping narratives

The third face of power, often described as invisible, involves the ability to shape information, beliefs, and worldviews through public narratives. Public health's increasing focus in recent decades on the importance of addressing social determinants of health is an example of influencing the third face of power. Using data, research, communications, advocacy, and other public health tools, practitioners have actively worked to shift people's mindsets from the dominant, individualistic view of what causes health and illness to a social and political view.[2]

Additional, nascent efforts are underway to shift public health narratives and worldviews to advance equity. This is particularly important in times of public health crisis, such as the COVID-19 pandemic, when framing of solutions tends to revert to primarily individual treatment and behavior. The case examples later illustrate how public health narratives can be broadened and deepened to achieve the structural and policy changes required for shifting power.

- In 2019, the University of Wisconsin Population Health Institute convened health equity leaders

across Wisconsin and facilitated a process to identify shared values and beliefs, understand narrative power, unmask current dominant narratives, and identify transformative narrative themes. The pandemic provided opportunities to disseminate these narratives and begin efforts to shift worldviews. For example, the Institute worked with public health agencies and community partners to emphasize how Wisconsin residents' "fates are interconnected" and that, rather than return to the prepandemic status quo, we can pursue a "fair and just recovery" by breaking down long-standing and unfair barriers to opportunities and creating a society where *everyone* can thrive.[25]

- The Minnesota Department of Health developed equity narratives[26] and trained more than 1500 public health professionals and partners on using narrative strategy. They developed specific narratives that convey "fundamental truths about the forces and factors shaping individual and community health" on a variety of issues including income, paid family leave, debt, transportation, incarceration, and housing. These narratives were incorporated into the State Health Improvement Plan. This work helped advance state minimum wage legislation and local paid leave policies.
- HIP and PHA led collaborative projects to shift narratives around incarceration[27] and taxes,[28] respectively. They incorporated these narratives into research reports and used traditional and social media to disseminate them. The incarceration-related narrative was grounded in beliefs such as "all people are fully human and deserving of dignity and fairness" to counter current dominant narratives that stoke fear, blame individuals, and propose punishment as the only solution, thus preventing health- and equity-promoting criminal justice reforms.

Discussion and Conclusion

Understanding how to shift power is still developing within the field of public health. New directions for the field are crucial for improving health and equity. Public health leadership can build from these leading-edge approaches, establish new practices, and commit to the difficult and long-term community power-building work that is required. Doing so is not risk-free, nor inevitable; public health leadership and practitioners must self-reflect on their commitment to advancing health and racial equity and their willingness to make sacrifices—including building collective power with those facing inequities—to fully and purposefully embrace advancing equity as their goal. Doing so takes courage and leadership.

The examples described in this article are innovative, intentional interventions to shift power that public health practitioners have experimented with in government, academic, and nonprofit settings. However, additional work is needed to better understand how to apply power theories and frameworks to on-the-ground practice, to develop trusting relationships with community organizing groups, and to support social movements in ways that most effectively address power imbalances. Here, we highlight 3 needs.

First, the public health field must continue this innovation. Current interventions rarely include analysis of or efforts to address power, so new approaches must be developed. Since these types of interventions are not common public health practice, this will require systems and leaders to take risks and work outside their comfort zone.

Second, power-building efforts must be evaluated to identify promising practices and to assess the effectiveness of collaborative approaches to community power building. Evaluation methodology that matches the scale and goals of these interventions must be developed. For example, methods to evaluate narrative and worldview change, a multiyear complex process, are just emerging.

Finally, public health entities must shift significant resources toward efforts to address power imbalances. Piloting and evaluating new approaches, scaling successful interventions, and increasing resources and capacity for power-building efforts among those

Implications for Policy & Practice

- To truly move the needle on equity, the public health field must recognize and take action to address power as a key driver of health outcomes and inequities.
- The Three Faces of Power is a pragmatic theoretical framework for understanding power and developing actions to address power imbalances in the context of public health practice.
- The real-world case examples provided in this article demonstrate concrete ways that public health practitioners in government, academic, and nonprofit settings are shifting power and building community power in their work.
- The public health field can learn from and build on these innovative examples to establish new practices, scale up promising approaches, and evaluate what works in order to shift power toward achieving more equitable outcomes.

facing inequities are necessary investments to move the needle on equity.

Although the struggle to advance equity is complex, these case examples illustrate that change is possible. We can reimagine public health practice by leaning into our values and acting now to shift power for the greater good.

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