Social Injustice and Public Health

Edited by: Barry S. Levy and Victor W. Sidel

Publisher: Oxford University Press Print Publication Date: Aug 2013
Print ISBN-13: 9780199939220 Published online: May 2014
DOI: 10.1093/med/9780199939220.001.0001

Strengthening Communities and the Roles of Individuals in Building Community Life

Chapter:
Strengthening Communities and the Roles of Individuals in Building Community Life

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DOI: 10.1093/med/9780199939220.003.0024

Introduction

Strengthening communities and the roles of individuals in building community life can help prevent disease and disability and expand resources for promoting social justice. In this chapter, we focus on addressing race and socioeconomic-related disparities experienced by persons living in geographically defined communities. We recognize that "communities" can take many forms, not all of which are tied to location, and that different strategies may be required for different types of communities. Communities have strengths, such as individual members, social networks, social support, social capital, and their capacity to identify and solve their own problems. Communities also have potentially harmful factors, such as oppressive social controls, limited connection to social resources in the wider society, and hazardous environmental factors. Understanding both the protective and the potentially harmful factors of communities is critical to a practice of public health that builds

communities and the roles of individuals as builders and sustainers of them.

Individuals are essential to community life and, when engaged collectively, can be the engines of community transformation and social change. Therefore, our focus is not on individualism, but rather on engaged individuals who recognize their interdependence. *Social networks* are the set of social connections among people; these networks can be characterized by their size, the qualities of ties among members, and the characteristics of members. Social networks have been linked to health outcomes through behavioral, psychological, and physiological pathways.[1]

Social networks may influence health by providing emotional, informational, instrumental, and appraisal support. Emotional support may affect health through the love and caring that people experience. Informational, instrumental, and appraisal support may help individuals' health by improving their access to material goods, resources, and services. Networks are a source of social influence—both by the influence of one person on another and by the influence of shared norms concerning health. Networks promote social participation and social engagement, and thus define and reinforce societal roles as well as provide opportunities for companionship. Networks also affect health by providing or preventing exposure to infectious diseases. In addition to affecting health directly, networks, through their patterns of associations, may afford opportunities for individuals to work in concert to solve problems and to take action. Therefore, social networks may be the mechanisms through which much community capacity for change is achieved.

Social capital pertains to the aspects of a social structure that facilitate action,[2] such as norms of reciprocity and civic engagement, social trust, and networks of social relations that can be mobilized for civic action.[3] Research linking social capital to health, though still in its early stages, may explain some differences in health outcomes.[4, 5, 6] However, a major problem in drawing conclusions from current research in this area is the lack of consensus on an operational definition of *social capital*, including the level at which it should be measured and the measures to be used in studies.[7]

The emphasis given to *social cohesion*—one aspect of social capital—and its relationship to health outcomes has been criticized for diverting attention from such structural determinants of health as income inequality, discrimination, and institutional racism.[8,9] Another critique is that social capital, when defined as social cohesion, can have both negative and positive social effects.[10] For example, social capital can be quite strong within antisocial groups, such as white-supremacy organizations, the militia movement, and neighborhood gangs.

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Community capacity comprises the characteristics of a community that enable it to mobilize, identify, and solve community problems.[11] Researchers have identified numerous dimensions of community capacity. Some of these dimensions have been linked to improved program implementation and health outcomes, both theoretically and empirically.[12,13] Community-level traits, leadership, resources, and patterns of association can be identified and utilized to solve community problems and contribute to community health improvement.[14] Mobilizing community capacity to identify and solve problems is a fundamental ingredient of changing oppressive social structures and patterns of meanings. Transformative changes cannot be sustained without engaged and mobilized citizens.

Optimism plays an important role in protecting individuals and their communities from the effects of chronic stressors. Hope and optimism at the individual level positively influence health and protect against the effects of stress.[15,16] In contrast, hopelessness is thought to diminish health.[17] In his essay “Nihilism in Black America,” Cornel West, an American philosopher, activist, and author of *Race Matters* and other books, discusses the problem of hopelessness in black America and its deeply ingrained effects on culture and society.[18] Optimism has not been investigated as a community-level construct, but it is a critical component of individual—and possibly community—transformation. Mediating structures, such as churches and community associations, may provide a means for oppressed communities to build hope and optimism by meeting some of their needs—such as the need to exercise leadership—beyond the needs met by resources provided through either government agencies or market forces. By working in partnership with communities in ways that build individual skills, strengthen organizations and institutions that communities control, and avoid paternalistic approaches that extract power from communities, community organizing can build hope and optimism.

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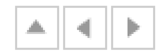
The protective aspects of community life are beneficial to community health and can be enhanced through community-organizing and community-building strategies.[19] Health workers and community development workers, working with community members, have successfully addressed issues such as infant mortality, crime, violence, teenage pregnancy, and gang-related activities. These community-building participatory approaches aim to strengthen the capacity of communities to deal with these issues and others.[19] Identifying and strengthening community resources—as opposed to focusing solely on community risks—is essential to bringing about the kind of community-based change that is needed to improve health outcomes.[19, 20, 21]

Addressing Social Injustice Through Community Transformation



Multiple multilevel strategies are needed to repair the fallout from social inequalities and social injustice and to stop the societal perpetuation of these problems. As public health workers, we need strategies to assist individuals and communities in their own transformation as they address health disparities and the root causes of these disparities. We need strategies to improve access to—and the quality of—facilities and services, including public health programming. We also need strategies to stimulate macroeconomic, political, and cultural change.[22]

During the past few decades, public health has emphasized developing and implementing effective approaches to reduce the burden of disease in populations, especially by primary prevention (which aims to prevent the occurrence of illness or injury before it occurs). Primary prevention strategies have focused almost exclusively on influencing behavioral risk factors of individuals, using policies and programmatic strategies with individuals and communities.

As we examine the *social* production of health disparities, we must ask, “How can we stop this injustice?” We believe the answer lies in community transformation and social change.

Building on the understanding of the relationship between individuals and societies proposed by Anthony Giddens,[23] a British sociologist known for his holistic view of modern socieites, we believe society is transformed when individuals and communities change the routinized patterns of social organization and meaning. In order to eliminate health disparities, individuals and communities need to come together to change these patterns in ways that alter the power structures that enable social inequalities to persist. This approach is not new; it has long been part of professional practice in the fields of community development, community organizing for health, and even some forms of comprehensive community-oriented primary health care. Examples appear in the literature of approaches that were viewed as real threats to the status quo, the political elite, and international interests.[24,25]

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In considering strategies to address social injustice and its effects on the health of communities and population groups, community health workers must partner with local communities, recognize and build upon community strengths, and use public health approaches that address the root causes of health disparities—while being cautious about potential dangers of their work. We propose the following set of principles, based on the work of one of us (J.W.H.) during almost five decades in the Mississippi Delta, Boston, and North Carolina. Building on his mentorship, the other three of us have applied these principles to our work in Baltimore, Washington, DC, and North Carolina.

Develop Authentic Partnerships with Communities

Do Not Extract Power from Communities

Altruistic motives and zeal for addressing health disparities and the social injustices that create and perpetuate these disparities often take the shape of paternalistic solutions. In poor communities, outside institutions exert decision-making power and control over the defining of problems, the identification of solutions, the implementation of programs, and the evaluation of success. Without the power to make these important decisions, the only choice that remains for community members is whether or not to utilize the services being offered. Public health programs are not the only ones that extract power from communities; so does virtually every governmental and non-governmental entity, including those in education, law enforcement, social services, health care, city planning, housing, and entertainment, as well as media organizations, religious institutions, charities, and private foundations. We must employ new approaches that respect the need for people to have control over the decisions that affect their lives.

Start Where the People Are

Public health workers and their organizations can address social injustice and health problems by joining with communities to address their concerns. Public health workers in communities need to start “where the people are.”[26] This principle is important from the perspectives of both ethics and practicality.[27] From an ethical perspective, starting “where the people are” acknowledges a community’s right to self-determination, liberty, and actions based on the values of the community members. From a practical perspective, problems and solutions defined by outside consultants or health workers have a long history of failure and mismatch with community motivations and concerns. Although health workers may be responding from a population perspective to critical health issues, such as cardiovascular disease, diabetes, or infant mortality, these concerns are rarely the same as those of community members. Therefore, when health workers focus solely on their concerns or the concerns raised by data, they may have difficulty getting community members involved. In contrast, when health workers join with community members in

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addressing their concerns, it is often possible to address not only community concerns, but eventually also the concerns of the health workers or funding agencies.

Understand the Local Context and Listen to the Community

In order to understand the role that the local context plays in the lives and health of community members, we must look beyond numbers and rates to the stories and experiences of community members. But, in order to be granted the privilege to hear these stories, we must enter into authentic relationships with people and institutions in the community. If disenfranchised populations are not having their concerns heard and addressed, it may be because no one is listening or no one is trusted. How can we listen if we do not interact in meaningful ways with the populations we serve? By listening to and hearing the voices of the people we serve, public health researchers and practitioners can better understand the social issues that most significantly affect their lives and their health. For example, one of us (R.E.A.) has explored, through focus groups, community concerns and notions of what makes a community a good place in which to live for women and children. Figure **24–1** depicts the contrasts between the broad set of concerns voiced by community residents and the narrow focus taken by typical programs for prevention of infant mortality. The residents’ concerns listed in this figure should be priorities for our shared action agenda to address.

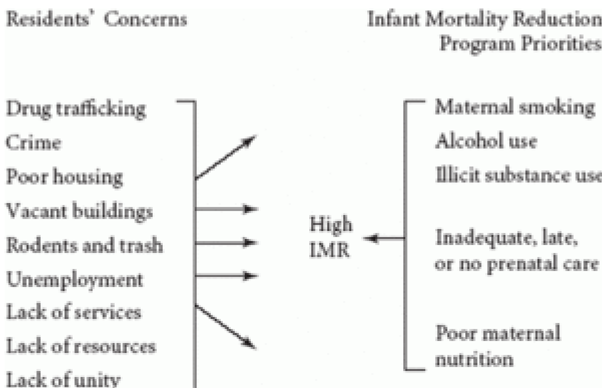

Figure 24–1
Contrasting community and program priorities. (IMR = infant mortality rate)

Nurture a Sense of Optimism and Hope

The erosion of dignity, of self-worth, and of a useful role in society have led many people to believe that their lives and their communities will never improve. This lack of hope can also be seen when some people in groups in the community believe that other people or groups are beyond

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being helped. The loss of hope can be threatening to the survival of a sense of morality and community among African Americans.[18,19]

Paulo Freire, a Brazilian educator and philosopher, described the dehumanization that occurs as a result of oppression and social injustice and the impact of this dehumanization on self-esteem:

> Self-deprecation is another characteristic of the oppressed, which derives from their internalization of the opinion the oppressors hold of them. So often do they hear that they are good for nothing, know nothing and are incapable of learning anything—that they are sick, lazy, unproductive—that in the end they become convinced of their own unfitness.[28]

According to Paulo Freire, the first step in surmounting oppression is critically recognizing its causes. In doing so, the oppressed can begin to see themselves and their humanity more fully. Public health strategies to restore dignity, self-respect, and regard for others are needed to repair the damage caused by societal oppression. Only when individuals see themselves as fully human can they act to end their oppression.

Recognize and Build on Community Strengths

Recognize the Resources That Exist Within Communities

Communities are built on strengths and assets—not on problems.[29] Understanding the community context in which health problems arise should include an assessment of community assets and ways they have helped solve previous problems. Public health workers are not the default source of information and advice regarding health in most communities. Local opinion leaders, trusted community members, and natural helpers tend to serve in this role. In African American communities, institutions parallel to those of the wider society have served as bases of belonging, self-esteem, leadership development, and social activism.[30] Because blacks were often not able to gain access to broader societal institutions or were not treated equally to whites when such access was gained, they were left to develop and nurture parallel institutions,[31] including fraternal organizations, clubs, and secret societies; economic and educational institutions, such as historically black colleges and universities; and—of great importance—black churches. These parallel institutions have facilitated the survival of African Americans, led the civil rights movement, and nurtured individual and community capacity.

Lay health advisor programs build on the strengths of African American churches and natural helpers to reduce health disparities.[32,33] Among the projects conducted by these programs in conjunction with these churches that have been aimed to reduce health disparities are those that have focused on nutrition,[34,35] breast health,[36] prostate cancer,[37] diabetes,[38] and physical activity.[39]

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Strengthen the Capacity of Local Institutions, Networks, and Community Groups

Addressing health problems through local institutions, networks, and community groups is an important strategy to help people to live healthy lives in their communities. According to *The Future of the Public's Health in the 21st Century,* a 2002 report of the Institute of Medicine:

> Government public health agencies, as the backbone of the public health system, are clearly in need of support and resources, but they cannot work alone. They must build and maintain partnerships with other organizations and sectors of society, working closely with communities and community based organizations, the health care delivery system, academia, business, and the media.[40]

Although formal public health institutions are in need of resources and support, community-based institutions they partner with may have even greater needs. As public health professionals work with community-based institutions, they must bring resources from the wider public health system to build the capacity of these institutions. Needs for capacity-building may include the development of basic technical skills, such as in budgeting and proposal writing, leadership, and financial and human resources. Strengthening local institutions, networks, and community groups makes it more likely that work to address health disparities will be sustainable. An important outcome of past community building has been the development of individuals who return to serve their communities after gaining additional training and education.

Strengthen and Expand Social Networks in Communities and Beyond Communities

Social networks influence the health of individuals in many ways.[4] They can produce adverse effects related to social control and reduced behavioral options that may encourage risky behaviors that are harmful to health. Social networks may provide redundant types of social support with less access to the goods and services of society if the members of the network are relatively homogeneous in terms of education, occupation, and social class.[41] We do not recommend an approach that simply tries to encourage community members to interact with one another, thereby expanding social networks in communities. Rather, we encourage strategies that build networks of support for community and societal change and for greater access to the goods and services of society.

In a 13-county area in eastern North Carolina, two of us (R.E.A. and J.W.H.) worked with a network of 105 churches in a major African American denomination. To develop the churches' role in promoting health among their members, the existing networks within churches needed to expand outside these churches' walls and into their communities. The training of lay health educators involved a combination of (a) dialogue/problem-posing workshops on the nature of community

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health problems, and (b) lectures led by local representatives of public health departments, health associations, and other community agencies. Involving professionals from outside the churches helped create connections between the churches and these professionals. The churches' networks expanded to include service providers with access to goods and services not routinely available. The connections were mutually beneficial. Church networks developed larger pools of resources for assistance on important community issues and the network of service providers, including county health departments and nonprofit organizations, such as the American Heart Association and the American Red Cross. As a result, they had greater access to the populations that they were seeking to serve.

Use Public Health Approaches That Address the Root Causes of Health Disparities

Use Ameliorative and Fundamental Approaches

In order to effectively address health disparities, we need to use both ameliorative and fundamental approaches to public health practice.[42] Ameliorative approaches target specific risk factors that are associated with health outcomes in a given community context, and facilitate development of protective factors to enhance the health of individuals, communities, and larger populations.[42] In contrast, fundamental approaches seek to transform the elements of society that give rise to inequalities and health disparities. We need to use both of these approaches at the individual, community, and societal levels. It should not be assumed that societal-level approaches will necessarily be addressing root causes.[42]

Maintain a Long-Term Perspective on Fundamental Issues

By maintaining a long-term vision while addressing immediate needs, public health workers and communities can contribute to reducing the social injustices that contribute to poor health. Communities may be better able to advocate and demand change when local public health work strengthens community leadership, expands social networks, and fosters community problem-solving. One of us (J.W.H.), reflecting on his work in the Mississippi Delta, described how a perspective on long-term social change was always a part of his framework, even when addressing immediate needs in ways that were non-confrontational.

The focus of much of the action was on practical concerns, such as digging wells, building outdoor sanitary toilets, and reducing health risks in the local environment. Small successes nurtured the belief that change was possible through collective action. Many who doubted the possibility of positive change began to attend meetings related to the health council and the farm cooperative. For many, this was a political awakening. People involved with these organizations were recruited by civil rights groups, such as Delta Ministry and the Mississippi Democratic Freedom

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Party, to lead voter-registration campaigns. Organizing strategies used to educate, recruit, and involve people in the farm cooperative enabled organizers to develop skills similar to those required for political action.

While Addressing These Important Issues, Build Race, Class, and International Bridges

William Julius Wilson, a noted Harvard sociologist, contends that the political muscle needed to address some of the social problems facing the United States cannot be achieved without a broad-based, multiracial coalition—one that focuses on issues that are important to most Americans and emphasizes their interdependence.[43] Among these issues are government policies to assist vulnerable families, trade policies that do not reduce employment opportunities or displace workers, monetary policies that promote full employment, livable-wage policies, and policies to restore American cities.

Many economic forces that have disproportionately affected African Americans have arisen from global economic forces that are non-racial in origin. For example, trade policies such as those of the North American Free Trade Agreement (NAFTA) have resulted in a decline in lower-skilled, low-wage jobs in the United States. Nearly half of recent job losses among less-educated blacks have resulted from the loss of manufacturing jobs.

The importance of building bridges among citizens of the United States and those of other nations is particularly relevant for environmental issues and trade agreements. Free-trade and investment agreements have undermined public health by increasing social inequalities, depleting natural resources, and increasing environmental pollution.[44] The importance of building bridges with activists from other countries has been demonstrated in the tobacco-control movement.[45] Stricter tobacco-control legislation in the United States has resulted in more aggressive international marketing of tobacco-control products. Partnerships among tobacco-control organizations in various countries have helped groups to frame tobacco issues in an international context and provide information, advice, and resources across borders. In addition, examples of egregious behavior by tobacco companies in other countries can be used sometimes to address their behavior in the United States. (See Box 21–3 in Chapter 21.)

Support Actions That Build Participatory Democracy and Engaged Citizens

Community-based strategies to address public health problems are most effective when the population is mobilized and engaged in the identification of problems and the development of solutions. Developing broad-based coalitions of existing community-based organizations, agencies, associations, and concerned citizens can be a powerful way to

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mobilize and engage communities. (See Box 24–1, which addresses strengthening communities in low-income countries.)

Box 24–1 Strengthening Communities in Developing Countries

Community capacity enables a community to reflect on its strengths and needs in order to improve its well-being and that of its residents. Strengthening community capacity can lead to better outcomes in health and social change. Participation in health and development programs can strengthen the voice of ordinary citizens and ensure their involvement in decisions that affect their lives and the life of their communities. Participation of community members also increases the impact of health and development programs and can lead to long-term sustainability. In response, individuals and groups who are actively involved become committed to—and feel increasingly capable of—improving their health and living conditions.[1]

The Community Action Cycle[2] (CAC) is a common method for strengthening community capacity and mobilizing communities towards collective action. Use of the CAC fosters a community-led process through which those people most affected by a problem organize, explore, set priorities, plan, and act collectively for improved health and development outcomes. The CAC is based on a social-systems approach to individual and social change—a process by which people "define who they are, what they want, and how they can get it."[3] The CAC and other empowering processes are grounded in the following principles:

- Sustainability of social change is more likely if the individuals and communities most affected "own" the change.
- Communities should be the agents of their own change.
- Persuasion and unidirectional transmission of information from external technical experts should be replaced by dialogue, debate, and negotiation among community members.
- Improving development outcomes should focus on social norms, culture, policies, and improvement of the supportive environment —especially where individual decision-making power is limited by strong cultural and gender norms.
- Community members who have been previously silent, inactive, or marginalized should be given a voice and encouraged to participate.

Participation should engage people in the decisions that affect their lives and promote self-reliance. In the context of health and development programs, self-reliance means creating and strengthening appropriate forms of interdependence among

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communities and governments, service providers, or other external agents.

There is a continuum of levels of participation and self-reliance. Attending a meeting without expressing opinions, for example, can be an important first step—especially for those without experience in having their voices heard. Later, these people can become more actively involved. In some cases, involving those who are most marginalized is not possible at the start of a project; their involvement may require additional work to enable them to believe that they are capable of participating. A step-by-step approach to participation may be more appropriate for individuals and groups who have been reluctant to participate in development programs or who mistrust external interventions.

The following examples represent the application of these principles in projects sponsored by Save the Children, a nonprofit organization that works to strengthen community capacity in more than 50 low-income countries, serving more than 33 million children and 19 million adults.

In Ethiopia, a network of care and support for 500,000 orphans and vulnerable children was established by linking and building the capacity of six international organizations, 36 in-country non-governmental organizations, and 575 community-based organizations. Community-based groups were strengthened to explore the issues affecting vulnerable children; to plan and act together to access, demand, and deliver services; and to mobilize and manage financial and human resources.

In South Africa, in an area where health services were underutilized and a wide sociocultural gap existed between service providers and community members, these two groups came together to jointly define “quality of care.” Community access to health services was improved by having ongoing dialogue, setting common priorities, and planning together.

In Bangladesh, community leaders in underserved areas are organizing and empowering men’s and women’s groups to develop ways to improve care and support of pregnant women and newborns. Community leaders receive training and support to facilitate dialogue within peer groups that enables participants to better understand why mothers and infants have been dying during childbirth, and to address local barriers by planning and acting together.

By strengthening community capacity, communities (a) learn how to apply political pressure to improve the quality of services, (b) generate and contribute additional resources not previously available to the health system, (c) facilitate changes in social

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strategies, structures, and norms to increase access to information and services for those who need them most, and (d) strengthen their ability to claim their right to respectful treatment. Through this process, community members' abilities to address many underlying causes of health problems, such as poverty and discrimination, are developed.

The following measures for strengthening community capacity may also increase participation:

- Supporting ongoing dialogue among community members regarding development issues, including health
- Strengthening the capacity of community-based groups in leadership, group maintenance, resource mobilization and management, external links to services, and use of data for decision-making
- Working in partnership with communities in all phases of project management to promote co-learning, in which "teachers" and "students" work together in the quest for knowledge, understanding, and wisdom

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Democracy in the United States is threatened by corporations and wealthy people who purchase access to government officials, especially since the *Citizens United* decision by the Supreme Court. As public health professionals working with disenfranchised communities to address

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health disparities, we need to use participatory strategies that maximize the potential for individual and community learning, empowerment, citizen engagement, and mobilization. Lessons learned and power gained through such strategies—multiplied across communities—can help to strengthen democracy and address social injustices. Geni Eng, a professor of health behavior at the University of North Carolina, and her colleagues have found that communities with higher rates of participation in addressing health issues are more likely to address other community issues.[13]

Work with Other Organizations to Address the Public's Health

Now that we are gaining an increased awareness of the power that context wields in the health of populations, public health professionals should embrace comprehensive approaches to improving the context of people's lives. This may mean that we become involved in issues not typically seen as part of public health. It may mean that we need to expand our set of partners to include those from other organizations seeking to improve the context of people's lives. The public health system does not always need to be the lead in local work to improve community health. Addressing the social determinants of health may require other agencies and/or communities to take the lead.

In addition, many of the upstream causes of health disparities are addressed by organizations in the community beyond the local public health agency, and therefore require action by everyone concerned with the public's health.[46] For example, public organizations, business organizations, government entities, and communities could develop fruitful partnerships to address health disparities resulting from the built environment. Together, transdisciplinary groups representing environmental health, community planning, economic development, housing, transportation, social services, public health, justice, and community health could collaboratively address issues associated with low-income neighborhoods. Partners might include local architects, developers, and nonprofit organizations such as Habitat for Humanity. Built-environment features that emphasize physical activity, such as parks and sidewalks, also strengthen community life by making social connections easier. Parks provide contact with other people and with nature—features of our environment that promote health.[47]

Funding for Community-Based Research and Public Health Practice Should Emphasize Community Building

With the increased attention given to the importance of context in population health, funding for research and public health practice should contribute to the process of improving people's lives. Greater emphasis should be placed on participatory research strategies, such as community-based participatory research (CBPR), that engage communities in the process of defining research priorities and developing research strategies. The community brings an understanding of the

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context, including issues of concern and knowledge of how the community "gets things done." Participation by community members helps to restore trust in the public health system and builds skills and community capacity that are important for an engaged citizenry. Funding for public health programs, likewise, should emphasize comprehensive and community-building strategies to improve the context in which people live. Changing behavior without changing the context in which it occurs is not likely to be sustainable. State and national funding agencies should consider requiring research staff members and project personnel to complete an orientation to ethics of community-based research and practice—similar to the online training required for research involving human subjects.

Continue to Exert Pressure from Outside the Community

The production of social injustice and health disparities is global. Addressing social injustice and health disparities therefore requires global coordination on such issues as environmental degradation, greenhouse gas emissions, biodiversity loss, water shortages, fishery declines, poverty, financial instability, taxation, food insecurity, trade in health-damaging products, and armed conflict—as well as governance.[48] What happens in our local communities has global effects, and what happens globally has local effects. For example, policies of the World Trade Organization result in disinvestment in small, family-based, sustainable agriculture, which, in turn, reduces food security.[44] Addressing these issues effectively will take joint action from both within and outside communities and across borders from members of community-based organizations, academic and scientific institutions, and government agencies.

Some Cautions

As public health workers, we often do not live in the communities where we work. Therefore, our understandings of these communities are likely to be tinted by our own cultural lenses. Furthermore, if organizing efforts go awry, we can leave these communities and escape many of the physical and social consequences of our actions. Therefore, it is critical for us to:

- Reflect on and understand our own relationships with the communities with which we work and our own relationships with power
- Be aware of the dangers of organizing among oppressed people
- Know when the challenges of addressing social injustice exceed our capacities as individuals

Working with poor communities to eliminate social injustice requires that we, as public health workers, think reflectively about our own views of the community, our own privileges, and our own comfort level with

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different roles in promoting health. Such reflection is critical when organizing or working with communities that are different than our own. Without intending to do so, we may demonstrate personally-mediated racism.[49] For example, devaluation of individuals based on race, which is one form of personally mediated racism, may be demonstrated by either an expression of surprise at someone's competence or by an attempt to stifle a person's aspirations. It occurs when we have a view of a community as "half empty" rather than "half full." Acting naïvely and with good intentions, we might do more for the community than necessary and therefore increase—rather than decrease—the dependency of community members. Communities have a vital life force and ways of doing things that may not be apparent to us as outsiders. It takes concentrated and sustained listening over time to discover how things work in communities and the ways in which communities get things done. Given our education and training, we might not challenge our own views of what the community has to offer and might believe that our way of doing things is more informed and more effective. All of these actions devalue what community members might be able to do.

As public health workers with professional training, we have a different relationship with power than do members of the poor communities with whom we work. Examining our relationships with power will help us avoid unintentionally holding the status quo in place. We must develop an ability and comfort to work with community partners to conduct a structural analysis of the conditions that enable disparities to persist. Powerful persons and institutions with which we work may be challenged by such an analysis. But, without this analysis, we may not see the ways in which we have privileges not held by the community members with whom we work. If we lack self-knowledge, our ability to work in partnership with the communities will be hampered.

Because using community and social transformation for eliminating health disparities involves upsetting and changing routinized patterns of power, it is usually accompanied by conflict. Root causes of health disparities, such as income and wealth inequalities, racism, and sexism, persist because of powerful interests, which must lose some power if meaningful change is to occur. As health workers and organizers, we face several dilemmas. Organizing is often dangerous, leading to backlash, exploitation, and oppression. Historically, in the civil rights movement, local leaders sometimes were beaten, jailed, or forced to leave after outside organizers moved on. At other times, local leaders and organizers were killed.

There are differing views about how the dangers in organizing should be addressed. One approach would be to temper social activism by having the community decide how far to take confrontation-based tactics—because the community is often left to address the fallout from these tactics. Building on an analysis of the root causes of injustice and of the

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powers that sustain it can enable us to enter situations with our eyes open and to anticipate potential backlash.

Not everyone is comfortable with this type of work. To grow as people and public health workers, we need to better understand ourselves and our work. Sometimes, we will recognize that we do not have the capacity for this work, or that, because of other circumstances, we must choose to work more indirectly with communities. In these roles, we still can choose to be supportive allies with communities and health workers. As examples, we can support community businesses, associations, and cultural activities; we can speak up for the rights and perspectives of communities in the organizations in which we work; and we can refuse to support or approve of organizations or individuals who undermine these communities.

Conclusion

Health disparities suffered by poor and minority populations are socially produced. They result largely from current and historical social injustice. Addressing these disparities requires approaches that are both ameliorative and fundamental, addressing both current problems and root causes. Comprehensive approaches are needed that work across the wide domain of social ecology—individuals, families, communities, organizations, institutions, and the broader society. Communities possess strengths and assets that can be used to address the health problems that they face. Communities can be strengthened in their capacity to address their current health problems and the root causes of these problems. Public health research studies and interventions in communities should be designed and implemented in ways that build community capacity and the skills of individuals to contribute to community problem-solving. Engaged and critically conscious people are needed to sustain work for social change.

Public health workers need new skill sets and intervention strategies to assist communities in meeting the challenges they face. Our understanding of the effects of contexts on health must include insight into how health problems are experienced by people living within these contexts. This understanding should lead us to consider broader approaches to improving the context of people’s lives by working collaboratively with communities.

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