A REVIEW OF EMPOWERMENT MODEL OF HEALTH PROMOTION IN PROMOTING HEALTHFUL LIVING IN COVID-19 ERA

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Abstract

This paper reviewed an empowerment model of health promotion and its effect on health and well-being and relates it to the COVID-19 era. The review found fewer instances where empowerment approaches had made a difference to the actual health and well-being of communities, although there was good evidence showing that community engagement was beneficial for social cohesion, social capital and strengthening relationships and trust among participants. The role of social and environmental determinants of health promotion especially money is an essential ingredient in coping during the COVID-19 era. Based on the available literature, it was found out that there are five key areas where empowerment strategies or interventions had improved individual health related outcomes in terms of healthful living. These areas were identified as: improved self-efficacy and self-esteem; greater sense of control; increased knowledge and awareness; behaviour change; a greater sense of community broadened social networks and social support; which are very necessary in the COVID-19 era. The authors suggested that further research is needed to establish the evidence for links between empowerment and improvements in the health status of communities.

Keywords: Empowerment, health promotion, healthful living, healthy public policy, COVID-19

Introduction

The fact that health follows a social gradient is no longer contested (Bambra, Gibson, Sowden, Wright, Whitehead and Pettigrew, 2010). Yet, contemporary public health problems are all too frequently attributed to individual behavior such as poor diet, lack of exercise, unsafe sex, smoking, drinking alcohol and using other addictive substances. Interpretations of this sort tend to be associated with a biomedical discourse and a deficit model of health that equates it with the absence of disease, rather than more holistic interpretations of health that encompass positive well-being. Such attributes are clearly overly simplistic. Nonetheless, they are still potentials damaging with regard to public health practice as responsibility for unhealthy behavior, and therefore by implication health, becomes delegated to the individual.

Health promotion has challenged such narrow focus on behaviour and has supported a more comprehensive analysis of the factors that influence health and well-being. In particular, it recognizes the fundamental importance of

environmental influences on health and the complex interplay between these factors and health-related behaviour. Environmental factors are taken to include not only the physical environment, but also psychosocial aspects and, importantly, the socio-economic environment. Acknowledging the importance of these wider determinants moves the primary focus of health promotion towards creating the conditions supportive of health and health behaviour.

The key to successful community-based health promotion is empowerment. In the context of health, empowerment refers to a process in which individuals or groups of people gain increasing control over their health (Payne and Hahn, 2000). To take control over health matters, individuals and groups must learn to 'liberate' themselves from a variety of barriers that tend to restrict health enhancement. In this sense, people learn to take charge of their lives, regardless of any current forces that discourage positive health changes. Empowered people and groups do not blame individuals or environmental realities for health conditions but focus on producing constructive change through dialogue and collaboration (McKenzie and Smeltzer, 1997).

The central dynamic of the empowerment model as contained in Green, Tones, Cross and Woodall (2015) is the interplay of education and healthy public policy in the promotion of health of the people, in this era of COVID-19, and this cannot be over emphasized. The development and implementation of policy is the essential precursor to the creation of health-promoting environmental influences. The empowering function of education not only strengthens individual capabilities for health-related action, but also makes a major contribution to the establishment of healthy public policy.

The empowerment model of health promotion shows how policy initiatives are necessary to improve service provision to meet the health needs of particular populations, more importantly; it identifies the significance of policy initiatives to address physical, socioeconomic and cultural circumstances. This position is reinforced in the Health in All Policies thrust of the WHO international health promotion conferences (WHO, 2009, 2013, Hamilton-Ekeke, Adeleke and Telu, 2019). The focus is more on reframing than on reorientation. In tune with modern multidisciplinary public health, it recognizes the contribution to health of a range of services whose primary raison d'être may not be health in any formal sense, for example transport, housing, economic development. However, all of these have a major impact on health and, indeed, on disease.

Description of the Empowerment Model of Health Promotion

Figure 1 sets out the main components of an empowerment model of health promotion and their interrelationships. Two major action strategies are included in the model. One is the traditional means of seeking to influence policy, such as lobbying. Advocacy is defined here as lobbying those who exercise power by those who have power but who are doing so on behalf of the relatively powerless. The

term 'mediation', which was incorporated into the Ottawa Charter list of major actions, refers to the process of mediating between competing interests.

The second and ultimately the most powerful means of producing policy change is to create a sufficient level of public pressure so that decision-makers and politicians at the national or local level feel obliged to change In a democracy, this might, in the final analysis, result in change by means of the ballot box. The catalyst for change is health education, but emphatically not the variety of health education that has been tarred with the same brush of 'victim-blaming'. Rather, following the precepts of critical theory, it might usefully be called critical health education and its purpose is radical and political.

The empowerment model of health promotion in Figure 1 on page 5 also includes an analysis of the essential contribution made by education to individual action. A training function was also included in the model to demonstrate the continuing importance of providing skills not only to communities, but also to the professionals who work in the various services. This training would include awareness-raising of the health-promoting role of the organizations, as well as making available the competences needed to communicate with clients and the general public, providing appropriate education and analyzing the impact of policy on health- and making appropriate adjustments in the interest of effectiveness and efficiency.

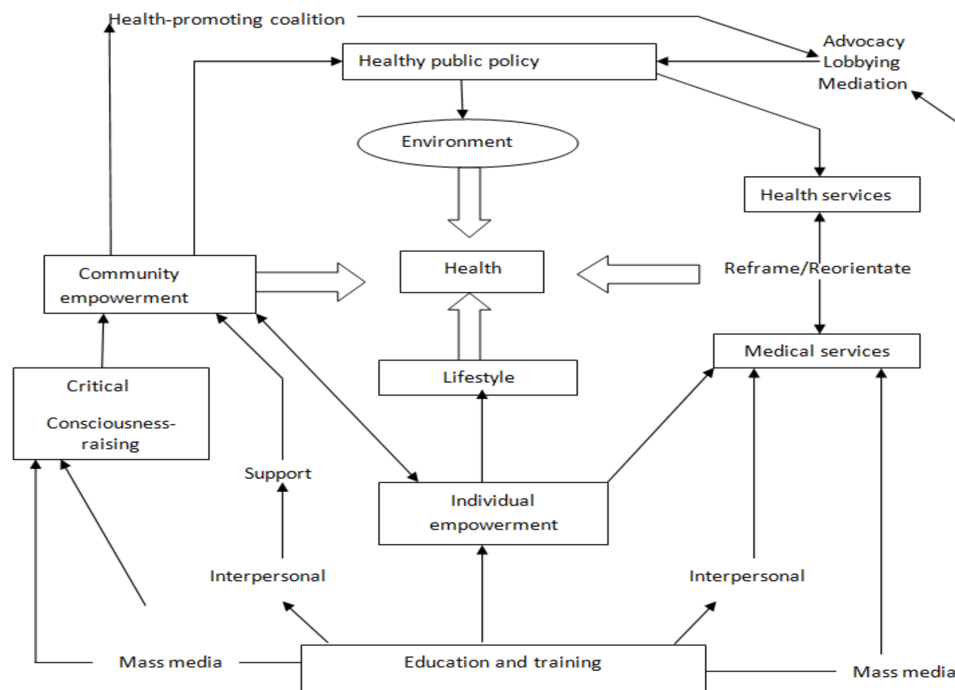

Figure 1: An Empowerment Model of Health Promotion (*Adopted from Green, Tones, Cross and Woodall, 2015)*

In the traditional health education function, the purpose was to persuade individuals to adopt behaviours that would result in the prevention of disease, both with regard to lifestyle and making proper use of medical services. The role of critical health education is not primarily that of persuasion (which is both ethically dubious and of limited effectiveness), but one of empowerment and support (at the peak of the COVID-19 in 2020, the palliative measures efforts of government, NGOs and individuals was a similitude of empowerment and support but its modus operandi in Nigeria was very faulty in the sense that the palliatives were locked up in warehouses instead of been distributed to the masses to ease the effects of the national lockdown).

Empowered individuals are more likely to make an effective contribution to community action, which, in turn, can contribute to their empowerment. They are also more likely to engage with the various services contributing to health in an assertive and productive fashion. They are almost certainly more likely to adopt a lifestyle conducive to achieving the objectives of preventive medicine than if they were not empowered. Indeed, one forceful assertions in the empowerment model of health promotion is that the successful adoption of an empowerment model of health promotion is not only more likely to achieve positive health outcomes in an ethical fashion, but also to be more efficient in attaining the important outcomes associated with the prevention and management of disease and disability (Woodall, Warwick-Booth and Cross, 2012).

The Empowerment Model: Critiques and Reservations

The empowerment model of health promotion is not without its critics. For instance, some might reasonably argue that empowerment is a fashionable term, distinguished by its lack of clarity in conceptualization and use (the same criticism could, of course, be leveled at health promotion itself and even the notion of public health). A second objection derives from the assertion that empowerment lacks a theoretical base. This assertion is fundamentally incorrect. What is undoubtedly more problematic is translating the rhetoric into action. For instance, Mayo and Craig (1995:2) cited the Bruntland Commission's conviction that the prerequisite for sustainable development is securing the effective participation of citizens, the World Bank's inclusion of empowerment as a main objective of community participation and the Human Development Report definition of participation in terms of people having constant 'access to decision-making and power'. Mayo and Craig also reiterated that functionalist sociologists such as Parsons (1967) considered that power in society was a 'variable sum' and thus 'the powerless could be empowered, and could then share in the fruits of development, alongside those who had already achieved power'. Mayo and Craig (1995) argued that an alternative, and perhaps more convincing, viewpoint is that power is a 'zero sum'. Accordingly, the powerful will be reluctant to yield their power in the interest of

empowering the powerless and will utilize the various ideological devices to keep the powerless in their place.

Unresolved challenges are also seen to exist in terms of the definition and operationalization of empowerment (Woodall *et al*., 2012). In a paper that posits a critical stance on whether empowerment has, in fact, lost its power, Woodall *et al*. (2012) contend that the concept of empowerment has become diluted in contemporary health promotion and has somewhat lost touch with its radical social roots. Christens (2013) is in agreement with Woodall *et al*'s (2012) conclusions that empowerment needs to be defined more precisely, that multilevel approaches are needed and that research is required that links changes at structural levels to changes at individual levels. However, Christens (2013) also added to the debate, pointing out some potential oversights in Woodall *et al.*'s arguments. He asserts the need to distinguish carefully between the uses of the terms 'individual' and 'psychological' empowerment and argues that critical consciousness is crucial to bringing empowerment back to its radical, liberationist roots, noting that this first takes place at the individual level.

It should hopefully be clear from the discourse above that power and politics are central to health promotion. It would be a mistake to underestimate the difficulties of challenging power structures. Nonetheless, we believe that sophisticated analysis grounded in sound theory can result in the development of empowering strategies that can achieve results. The empowerment model of health promotion is advocated on grounds of ideological soundness, practical effectiveness and standing up well to ethical scrutiny as a strategy to promoting healthful living during the COVID-19 era.

The Critical Health Education Role in Health Promotion

The role of health education *vis-à-vis* health promotion and the emergence of health promotion effectively marginalized health education by shifting attention towards the broader determinants of health and the need for a policy response. Yet this begs the question of how change is to be instigated and what processes should be put in place to improve the health of populations and, indeed, individuals. The primary driver has to be health education. While it is acknowledged that health education requires a supportive environment to achieve its goals, the converse is all too often overlooked. The development of healthy public policy to create a supportive environment is dependent on health education. As Figure 1 on page 5 makes clear, the development of healthy public policy requires some form of learning - and *ipso facto* education - be it among policy-makers themselves, advocates or communities seeking change.

Critiques of health education have centered on its individualistic, victim-blaming orientation. However, what the critics are actually attacking is the preventive medical model of health education. Alternatively, coexisting models of health education - especially the more radical, empowering models are overlooked,

effectively discarding the ‘health education baby with the victim-blaming bathwater’. Health education has a key role in tackling the structural determinants of health. Even at the individual and community levels, health education can have an empowering and emancipator function. It can also facilitate the voluntary adoption of health-enhancing behaviour.

The review by Tilford, Green and Tones (2003) of the values of health promotion supports the continued relevance of health education that is empowering and in tune with the precepts of critical theory. Tilford *et al* (2003: 120) asserted that values influence the ways that health issues are understood, the ways that knowledge and theoretical bases are developed and the nature of strategies identified for health improvement. Values also influence the selection of activities that are undertaken to promote health and the priorities accorded to actions, the balance between activities at individual and population levels, the relationships with individuals and communities who participate in initiatives, the goals which are being sought, and decisions about means and ends in achieving goals. The empowerment model of health promotion in Figure 1 on page 5 also concluded that health education, especially using a critical empowerment model, still has an important part to play in health promotion and public health. Health education can thus be a major driver within an empowerment model of health promotion - shedding its behaviourist, victim-blaming associations.

A working model is proposed that includes physical, mental, social and spiritual health and incorporates positive well-being as well as the absence of disease; although health is influenced by human agency, structural factors have a major influence on health and health-related behavior; health promotion is a discipline with its own ideology and core values. These include equity and empowerment along with health as a right, social justice, voluntarism, autonomy, participation and partnerships; ethical health promotion practice requires attention to these core principles along with the more general principles of beneficence, non-maleficence (the principle of non-maleficence holds that there is an obligation not to inflict harm on others. It is closely associated with the ‘*maxim primum nonnocere*’ - first do no harm) and the pursuit of the public-good; power is a key factor in relation to individuals' health behaviour and health choices (Woodall, Raine, South and Warwick-Booth, 2010). Power also shapes discourse about health and health promotion; while different models of health promotion exist, the case is put forward for an empowerment model; health promotion should generally uphold the principle of voluntarism, but the use of more coercive methods may exceptionally be justified on the grounds of utilitarianism, paternalism or social justice; health promotion has a specialist role within a wider, multidisciplinary response to improving public health; critical and empowering.

Key Principles of Health Promotion and the Handling of COVID-19 Pandemic

The World Health Organisation (WHO, 1984) set up a programme on health promotion which sees it as a 'unifying concept', bringing together 'those who recognise the need for change in the ways and conditions of living, in order to promote health'. It defines health promotion as the 'process of enabling people to increase control over, and to improve, their health'. Income, shelter and food were acknowledged to be primary requisites for health. Importance was also attached to the provision of information and life skills, the creation of supportive environments providing opportunities for making healthy choices and the creation of health-enhancing conditions in the economic, physical, social and cultural environments. The WHO (1984) document outlined the key principles of health promotion as:

- i The involvement of the whole population in the context of their everyday life and enabling people to take control of, and have responsibility for, their health;
- ii Tackling the determinants of health – that is, an upstream approach, which demands the cooperative efforts of a number of different sectors at all levels, from national to local;
- iii Utilising a range of different, but complementary, methods and approaches – from legislation and fiscal measures, organisational change and community development;
- iv Effective public participation, which may require the development of individual and community capacity;
- v The role of health professionals in education and advocacy for health.

During the COVID-19 pandemic, the action required was an integrated effort to encourage individual and community responsibility for health along with development of a health-enhancing environment which was seen in most quarters. Although, the health promotion principle document reflected a commitment to voluntarism and formally acknowledged the risk of dictating how individuals should behave; government applied some level of coercion in penalty and defaulting fine payments. Other potential problems of health promotion during the pandemic included an overemphasis on individual behavior rather than the social and economic determinants of behavior and the possibility of increasing social inequality if the varying capacity of different social groups to exercise control over their health was not tackled. This was very obvious during the pandemic as some household in some water-deficient communities could not afford to have regular hand wash. The pandemic brought untold hardship to many low-income households as it involves purchase of items like: facemasks, disinfectants, hand sanitizers etc. there was also sky rocking of prices of commodities and even food prices which made coping during the peak era an uphill task. Government handling of the pandemic by imposing fines and sanctions especially in the early pandemic

where law enforcement agents took undue advantage of airing public to enrich themselves compounded the COVID-19 problems for the citizenry.

The COVID-19 brought into limelight the accusation of health education and promotion of 'victim-blaming' – a term attributed to Ryan (Ryan, 1976) as it renewed interest in the importance of social and environmental influences on health status both directly and indirectly by shaping behaviour. Of particular concern were the emphasis on individual responsibility and the failure to recognize constraints on individuals' behaviour – most notably their economic and material circumstances. The essence of victim-blaming lies in attempts to persuade individuals to take responsibility for their own health while ignoring the fact that they are victims of social and environmental circumstances. Accordingly, Ryan argued in his quote that the fundamental factors governing health were 'power and money'. He quoted as follows:

> *'Being poor is stressful, being poor is worrisome; one is anxious about the next meal, the next dollar, the next day; being poor is nerve-wracking, upsetting. When you're poor it's easy to despair and it's easy to lose your temper. And all of this is because you're poor. Not because your mother let you go around with your diapers full of bowel movement until you were four; or shackled you to the potty chair before you could walk. Not because she broke your bottle on your first birthday or breastfed you until you could cut your own steak. But because you don't have any money' (Ryan, 1976: 157 cited in Green et al, 2015).*

Conclusion and recommendations

This paper reviewed the empowerment model of health promotion as put forward by Green *et al* (2015). Green *et al* (2015) identified different models of health promotion and argues on ethical, ideological and even pragmatic grounds that health promotion should subscribe to an empowerment model. Empowerment approaches recognised the reciprocal relationship between individuals and their environment and the complex interplay between agency and structure. The empowerment model supports the achievement of both disease prevention and positive health goals, which the reviewers of this article subscribed to especially in promoting healthful living during this COVID-19 era. The empowerment model of health promotion is more obvious and apt in the COVID-19 era as it brings to fore the interplay between the environment and man's likelihood of contacting the virus, and the roles of agencies (Government and Non-Governmental Organgisations) in the fight against COVID-19. Kudos must be given to the agencies for their roles in the timely intervention in terms of advocacies, sensitisations, and even in the development of vaccines. The challenge today lies in the uptake of the vaccines and equitable distributions of same globally as 'none is safe except all are vaccinated'.

Based on the salient emphasis on the social and environmental determinants of health promotion especially in the COVID-19 era, it is therefore recommended that since money plays a vital role in the adherence to the COVID-19 protocols, government, non-governmental organisation as well as spirited individuals should step-up their marks in the provision of palliatives to cushion the effect of the pandemic which is still much with us.

Healthful and equitable public policies should be enacted to help bridge the wide divide between 'the haves and the have-nots'. The empowerment model of health promotion reviewed in this article also brought to fore the importance of education and training in the promotion of health, it is therefore recommended that training of health personnel in innovative strategies of reaching the underserved is very important. Advocacy, lobbying, and mediation through mass media are avenues/channels of empowering the population to take control of their health. The authors suggested that further research is needed to establish the evidence for links between empowerment and improvements in the health status of communities.

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