Health Promotion and Empowerment in Collaboration: Theoretical Underpinnings and Methodological Challenges when Creating a Health Equity Program in a Vulnerable Area

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Abstract

In Sweden, as in all other countries, there are inequalities in various areas, such as health and wealth. Research has established a social gradient in health, which means that socio-economic groups differ regarding health status. Furthermore, in many cities today there is segregation and some areas are more “socially vulnerable” than others. Some of these differences between groups and areas can be regarded as unjust and thus constitute inequities.

The aim of this paper is to present the creation of a health-promotion innovation program whose purpose is to counteract health inequities in a “vulnerable” urban area in southern Sweden, and to discuss the theoretical and methodological foundations of the program. It does not, then, present any final health outcomes, but rather, gives a description of the, rather complex, initiation and launching of the program, which can in itself be seen as a kind of result.

The research carried out in the program is Community-Based Participatory Research (CBPR), grounded in Participatory Action Research (PAR). The paper presents the CBPR program from its start to the present, including its rationale, and sets forth its theoretical underpinnings, i.e., ideas about place, empowerment, health promotion, “human nature,” communication and dialogue, and health equity. It closes by discussing some potential methodological and philosophical problems, namely, issues related to health equity, empowerment as a process, power relations, and community participation in the outcome evaluation.

Introduction

In Sweden, as in many other countries, there are inequalities in various areas, such as health and wealth, and those inequalities have grown during the past 30–40 years. Research has, furthermore, demonstrated that there is a social gradient in health [1], which means that (in general) the higher your social position, the better your health, and vice versa.

Wealth and health vary between areas where people live. In many cities today, there is segregation and some areas are more “socially vulnerable” than others, which means that there you will find more relative poverty, more unemployment, more social exclusion, overcrowding, and low levels of social capital, education, and social status – factors that are, statistically, determinants of ill health [1, 2, 3, 4]. The program described in this article is specifically concerned with an area of this kind, in that it is a program aimed at addressing health inequities.

Segregation, social position, and health are also related to migration and some of its effects. Some groups of migrants (in this context mainly non-EU migrants) risk finding themselves at a low point of the gradient of health.

But in vulnerable areas there are also resources and strengths which can be utilized under favorable conditions. Moreover, in such areas there is often a strong sense of belonging. Research has shown that

“place identity” is important in building a community [5]. This is something programs like the one this article presents can profit from, as it may be conducive to innovation and progress.

The Aim Of The Paper

The aim of this paper is to present a program whose purpose is to counteract health inequities in a “vulnerable” area in a major city in southern Sweden, and to discuss the theoretical and methodological rationale of that program, including some possible theoretical and ethical problems.

Choice Of Study Site

The researchers chose the district of Lindängen, situated in the south-eastern part of Malmö, one of Sweden’s larger cities, as the study site for the program. Lindängen is a mixed area with both apartment houses and townhouses, with approximately 7,800 inhabitants [6], around 75% of whom are first- or second-generation migrants. This can be compared to the whole city, where approximately one third of the population are first- and second-generation migrants [6].

Unemployment is around 50% in both men and women (ibid.), which partly explains why the average income is low [6]. The level of welfare relief in the area is about twice as high as the average in Malmö [6]. The number of children living in economically vulnerable households is high in the greater area that Lindängen belongs to, especially in migrant families, where it is around 40% [7:54], but also in families where the parents were born in Sweden (approx. 17%).

We have no data on the level of proficiency in Swedish in the population, but it can be estimated to be relatively low, especially among the adult, or older, population, not least since the unemployment rates are high. The children are mostly fluent in Swedish, since they attend Swedish schools.

Reduced health and longevity are expected in the community, as many determinants of ill health are present in the area, such as unemployment, relative poverty, low educational levels, and poor health literacy [1].

Participatory Action Research

The research carried out in the program is Community-Based Participatory Research (CBPR), rooted in Participatory Action Research (PAR). CBPR has been established during the last 25–30 years as a research intervention approach within public health, health promotion, and other health sciences, and has proved effective in reducing inequities [8, 9, 10]. It involves partnerships that can be described as a “collaborative effort between community, academic, and other stakeholders who gather and use research and data, build on community strengths and priorities, and adopt multi-level strategies to improve health and social equity” [10:3].

PAR (including CBPR) is a form of research where the research subjects are co-researchers [11, 12, 13, 14; see also 15]. This means that, ideally, the participants are not just ordinary, “passive” research subjects, but contribute scientifically at various stages in the research process. It also means that the research process is dialectical and circular, in that there is a continuous reflexive dialogue between the researchers, participants, and other stakeholders, where they together (re)formulate what is being done, how, and why [14]. Thus, the present program is not research “*on or about*” people in Lindängen, but “*in and for*” the community [15:156].

When the community members participate in the research, the knowledge gained will be more accurate and useful, since there is a multifaceted collective working together, bringing in various perspectives on the phenomenon studied [16:8, 17]. This leads to a democratization of the production of knowledge [17], which is also part of a feminist approach to science [18]. PAR is therefore about knowledge mobilization, not knowledge transfer [9]. Knowledge transfer often leads to disqualification of service users’ knowledge, whereas knowledge mobilization focuses on creating knowledge together with different stakeholders. Leaving out local voices and stakeholder perspectives in the research processes risks leading, first, to incomplete knowledge, and, second, to “epistemic injustice” [19, 9], i.e., an injustice that arises when a person, because of some prejudice regarding the group to which they belong, is not considered as epistemically credible as people belonging to other groups, such as providers of services, or academics [19].

Finally, since PAR/CBPR has a critical, reflexive, and emancipatory, outlook [see 20, 21], the research performed is not just about observing, interpreting, or theorizing, but will not leave things as they are. Thus, projects of this kind should result in positive and sustainable effects on the population in question [16, 12, 13, 18].

The Theoretical And Conceptual Framework

There are a number of theoretical aspects of the program (and the research) that need to be highlighted. We will briefly present the key concepts and theoretical assumptions underlying the study, namely, place, empowerment, “human nature,” communication and dialogue, health promotion, and health equity. In earlier publications, we have discussed some of these concepts and their complex relations in depth (see authors’ references).

A basic assumption of the study is that people can govern themselves, and find solutions to their various kinds of problems, given that they are provided with the means and opportunities for doing so. This also goes for so-called vulnerable groups. What people usually need in order to increase their self-governing capacity are tools for empowerment, such as consciousness raising and skills, as well as a supportive environment [22, 23, 24, 25].

Place

Place is a key factor when working towards health promotion in CBPR [26]. In CBPR projects, a sense of community is created through a fair partnership. For the researchers, this means establishing such a partnership with people in public places within a geographical area.

Moreover, John Eyles and Kevin Wood [27], among others, have shown that there is a correlation between attachment to place, in our case a neighborhood, and health. They see the local place as an interactive relation between social structures and material conditions and a person's perception of her place in the world, which in turn affects her health.

Places where people live and spend their everyday lives are crucial for their identity and attachment to society [28] and research has shown that "place identity" is important when building a sense of community, as well as contributing to an increased feeling of security [29, 5]. However, when there are high levels of unemployment, poverty, illness, and criminality in a place, there is also a tendency to stigmatize people living there. The stigma can then become part of their identity, and lead to reduced hope for the future, and increased insecurity [30].

In a modern society, security is more or less embedded in our social and public institutions, i.e., the norms and rules that structure our actions and behavior patterns [31]. When this is no longer provided by local public institutions, people also lose their basic security [5]. Since people in general strive for security, they will often create their own "institutional" contexts, mostly where they live, i.e., their local place or neighborhood. They seek a substitution and might find it elsewhere, perhaps in a criminal gang, or in a religious extremist group.

To the extent that the program succeeds, it will contribute to a sense of place, identity, and security, and this is, in turn, expected to lead to increased empowerment and better health.

Empowerment

There are several suggestions as to how the concept of empowerment should be defined [32, 33, 34, 35, 25]. Most of these suggestions converge on two key aspects of empowerment, namely, *what* to achieve (a state or goal), and *how* to achieve it (the process) [23].

Firstly, empowerment as a dynamic state, and a goal for action, is for an individual (or a group or community) to *have or gain control* over their health and life. But everything in a person's life is not equally important. Therefore, a theory of empowerment should focus on what is most important for the individual to control. One suggestion is that it is primarily the individual's *quality of life* [36]. But it is often difficult, if not impossible, to directly control quality of life, not least since a person's quality of life is influenced by many factors that are out of control for the person, such as politics, the economy, and other people. Therefore, it seems more reasonable to require that the individual has as much control as possible over the *determinants* of their quality of life [23, 37]. We cannot develop a theory of quality of life here, but only note that we favor a modified desire fulfillment theory. This theory holds, very briefly, that a person's quality of life depends on her having her authentic (i.e., autonomous and informed) final desires fulfilled [38]. Thus, it is up to the participants in the program to determine what their own life goals are.

Secondly, empowerment has to do with how professionals work with the people they seek to assist. The main idea is that the empowerment approach makes the participants collaborators in the change process [39, 35, 25]. In short, empowerment as a process means that the participants have as much control over the change process as possible, and that the professionals involved act as facilitators in this process [23, 24].

In our program, the goal of the CBPR model, which uses empowerment as a process, is to reach empowerment for the Lindängen inhabitants, and this is, furthermore, expected to lead to better and more equitable health. Several systematic reviews of health-promotion projects working with empowerment (as a process) conclude that empowerment (as a state) and health are achieved, at least to some extent [40, 41, 42, 43].

“Human nature”

The CBPR approach takes for granted, as said, that people themselves have, at least potentially, the internal means for solving their own problems, assuming that they can develop certain skills and get access to opportunities. As the educator Paulo Freire puts it, the researcher has “to have faith in people; to believe in the possibility that people can create and change things” (in [14:69]).

Thus, the approach of our program is rooted in humanistic psychology and, to some extent, existentialism. Two important figures in these traditions are Freire, who had an existentialist outlook, and the psychotherapist Carl Rogers. All people have within them a “tendency to actualize” their inner potential, Rogers claims [44:351]. In Freire’s words, people ontologically and historically strive to become more complete human beings [45: 51]. This is a creative force, which is also constructive, realistic, and social [44:193–195, 347 ff.]. Hence, the approach assumes that under favorable conditions people will take action and fulfill (some of) their potentials.

Such conditions involve other people – people that can help create foundations for learning and development through what Freire calls a liberating pedagogy [45]. According to Rogers [44], three psychological factors are important on the part of a facilitator, namely, an empathic attitude, unconditional positive regard, and congruence (authenticity, or genuineness). The last point is about the facilitator entering into the relation as a fellow human being, not as a detached expert. For both Rogers and Freire, it is about establishing true “subject-subject” relations [46:17]. Freire, furthermore, sees pedagogy as an activity where everyone participates on equal terms, and learns through action (praxis). People cannot be taught or liberated, but they can themselves learn and become free through actions and “consciousness raising” [45:113, 47]. Consciousness raising is about autonomously, as a result of a genuine dialogue, reaching an insight about the world and one’s place in it [46:17].

Importantly, in encounters where people are met with empathy and an attitude of unconditional positive regard, people’s autonomy and dignity are preserved, as they are perceived as fully competent persons of equal worth. Besides being an ethical approach [48]Banks and Brydon-Miller, 2019), this also leads to

growth, in the sense of becoming more congruent (authentic) and therefore more self-aware, reflective, and responsible, and better at making autonomous and constructive choices [44:154–155, 189–192], as well as in the sense of becoming more human, and less alienated [45:81].

Communication and dialogue

The term “dialogue” is a recurring one in Freire [45]. Dialogue “as a meeting between people in order to ‘name’ the world, is,” he claims, “a fundamental requirement for their true humanization” [45:146; our translation from Swedish]. According to Kemmis and McTaggart, reflexive dialogues “engage participants in a collaborative process of social transformation” [49:579].

From a communicative perspective, these dialogues, or, in Freirean terms, pedagogical encounters, have similarities to Habermas’ idea of an *ideal speech situation* [50:86 ff.]. It is a situation in which all people involved have an equal right to participate in the dialogue, i.e., everyone is free to introduce or question any assertions, as well as expressing “attitudes, desires and needs” [Alexy in 50:89], and thereby also influence decisions. In this situation, which is free from coercion, rational argument is paramount. It is ideal in the sense that we seldom or never encounter such a situation in real life. Nevertheless, it can act as an evaluative ideal, e.g., in programs like the one presented in this article.

Health promotion

Much has been written about the practice of health promotion, but not equally much about the concept. Lennart Nordenfelt [51, 52] is one exception [see also 33]. Here is the description of health promotion that we embrace [adapted from 53, 54].

First, health promotion, be it performed by an individual or by a collective, is an *intentional* activity, i.e., there is a clear aim of trying to increase, or maintain, someone’s (individual or collective) health. Thus, no action that unintentionally leads to positive health outcomes should count as a health-promoting *activity*, since that would make the concept too broad. Note that someone might be the target for their own health-promoting action [51], as when a group of friends decide to take weekly walks in order to improve their health.

Second, health promotion covers activities that target various aspects of positive health. We will return to the concept of health in a later section on outcomes.

Third, health promotion activities target healthy people, or, if someone is unhealthy, focus on strengthening the present healthy features, including general protective factors, of the person. To the extent that the intentional activity instead addresses an illness, a disease, or a disorder, or specific risk factors for these kinds of conditions, it is either treatment or prevention [55:28–29]. Health promotion and disease prevention are, of course, compatible, and sometimes overlapping, activities [53, 54].

It might seem paradoxical in a PAR project that someone, e.g., the researchers, (intentionally) “does” something to the community participants, when the idea, as we saw, is to hand over power over the

process to the individual or group in question. This need not be a problem, though, since we (as researchers) only initiated the program, with a very general purpose (health equity), and then, as best as we can, facilitate the community in the process towards achieving their own concrete health aims.

Thus, we follow the WHO in its *specific* suggestions, found in the Jakarta Declaration [56], which says that health-promotion activities should be carried out together with the populations concerned, drawing on their own experiences, aspirations, and preferences, and, in doing so, strengthening the abilities of the participating communities to take action in order to influence the determinants of their health.

Health equity

Equity is a major concern of the program. Some inequality is normal, and expected, in most societies, e.g., when longer educations, or riskier work, result in higher salaries, or when some unfortunate people live shorter lives due to genetic disorders. An *inequity* is an inequality that is unjust [58]. When we see that systematic patterns evolve where some groups have better health than others, and where these differences could be changed through social intervention or policy, i.e., are not necessary [58], we can suspect that there is some degree of inequity, e.g., unequal opportunity for health [59]. This, in general, assumes that the pattern that evolved in the community in question was not one the community was itself (autonomously) responsible for, and valued [58, 59].

Thus, most vulnerable individuals and groups are not themselves, at least not fully, responsible for their own situation [60]. Rather, the current situation is, to a large extent, the result of social and political, and therefore, at least partly, controllable (e.g., by politicians) processes. We consequently assume that health differences between groups, e.g., the four- to five-year difference in life expectancy found between different districts in Malmö [3], do not have to be as large as they are. Focusing on inequity, then, morally motivates the program.

One way to address inequities is to try to “compensate” those groups that are disadvantaged. The opportunities we together create in the Lindängen program, through its various activities or projects, are intended to counter some of the prevailing inequities, primarily those related to health and empowerment.

The Lindängen Program: The Framework

Our overall purpose being improved and equitable health, we strive to achieve this result through creating a CBPR model for health promotion. The model is expected to serve as an example for other work in similar neighborhoods in Sweden when building community capacity in a “place,” in that it will, based on the community’s own initiatives and needs, create health-promoting activities close to home, open to everyone living there, and free of charge. This will strengthen the place identity of the participants, and, through empowerment processes, enhance community power.

The program’s immediate aim, however, is to create and test various innovative health strategies. In doing so, we focus on specific health targets identified by the community members in Lindängen themselves, and involve them and other local stakeholders in the planning process for the specific innovations related

to those health targets. Thus, the community, together with other stakeholders, has formed a multi-stakeholder perspective – one that seeks to further the health of the community through participatory and cooperative strategies [61, 62].

Sweden's innovation agency, Vinnova, is co-financing the program [63]. A great number of stakeholders¹ are involved in the program, and one initial, major innovation is that it uses a *quintuple helix model*, with partners from all sectors in society: 1) the academy, 2) the city, the region, and the county, 3) the commercial sector, 4) NGOs, and 5) the community members themselves [64, 62]. In total, 13 organizations and businesses are involved in financing and contributing to the program, besides Vinnova. To our knowledge, involving such a broad range of sectors and actors is quite uncommon.

Our goal is also to evaluate the program together with the community, in order to identify what policy changes are needed to promote health for marginalized populations in creating health equity. So-called co-creative labs function as spaces for dialogue and communication [45, 50] between community members and stakeholders in order to develop an understanding of the community members' specific needs and how to create changes. These dialogues follow participatory principles.

Early on in the process, the university initiated the creation of a strategic steering group, consisting of representatives from the university (e.g., the Vice Chancellor), the Region of Scania, Malmö City, other stakeholders, and community members (represented by three participants). This group has an advisory role and follows the various projects (co-creative labs) of the program, analyzing existing structural and other barriers, and seeking new possibilities in the quintuple helix collaboration [62].

Moreover, the stakeholders created an operational secretariat localized in Lindängen (ibid.). It consists of the program leader (the second author), the health promoters (see below), and stakeholders that have personnel localized in Lindängen, e.g., social workers from the social services in the city, and the Red Cross. Its mission is to help communication flow between the various co-creative labs, but, importantly, also between the community and the steering group. This is, furthermore, a place where conflicts between participants and/or stakeholders are brought up, discussed, and solved. Via the secretariat, members of the steering group gain knowledge about the progress made in the various labs. They can then convey this knowledge to their respective organizations, so that they learn and develop new strategies within the organizations themselves.

¹ The stakeholders were, apart from the community itself: Malmö University, Malmö City, the Skåne region, the County Administrative Board, Save the Children Sweden, the Red Cross Sweden, Skåneidrotten, Semcon, Apoteket hjärtat, Needsdrive, Trianon, Finsam, and TEPE.

Creating The Cbpr Program

An overview of the program as it developed:

- Building trust in the area (2016): "Future workshops"

- Strategical planning (2017): CBPR Model
- Establishing health-promoting co-creative labs in the neighborhood (2017)
- Employing citizens as health promoters for the labs (2017)
- Activities in the co-creative labs (2017 and ongoing)
- Collaboration, activities, and the health of the participants, are continually monitored together with the community participants and health promoters, through participatory means (2017 and ongoing).

Preparations for the program began during 2016, when we conducted three larger workshops to which all the community members in Lindängen were invited. However, before these workshops were initiated, we (in particular the second author) made weekly, often daily, visits to Lindängen during three months, in order to establish contacts with possible stakeholders, not least the community members themselves. This had two functions: 1) to find collaborating partners and organizations rooted in Lindängen, and 2) to build trust in the community by becoming known to parts of the population.

During this time, information about the pending workshops was distributed through various fora, e.g., meeting places and already existing networks, one of which was a women's network to which a great number of Arabic-speaking women were connected, and by putting up posters in key social meeting places, such as the library, the healthcare center, the school, and the youth recreation center.

Approximately 150 community members participated in the three workshops initiated. The participants consisted of men and women in all age groups, children, and families. They also represented a great number of nationalities. These meetings were inspired by Robert Jungk's method for social innovation, which involved the participants in visionary planning "from below," so-called future workshops [65]. In these workshops, the academic initiators (among them, the second author) discussed various health and social issues in dialogue with the participants, taking into account their desires and previous experiences. An interpreter was used when required (mostly to/from English and Arabic). The three workshops, each lasting for four hours, established three major health-related themes: 1) physical activities in the area, 2) self-care of different kinds, and 3) secure environments. It was also considered important by the participants that the subsequent activities were related to already existing urban meeting places in Lindängen, such as local community houses, schools, and leisure places, thus using well-established and accepted social structures. This illustrates the importance of place.

After this initial process, the researchers invited other stakeholders from different sectors in society (commercial, civic, non-profit, etc.) to discuss what had been suggested in the future workshops. In this discussion, community members in the area, together with the researchers and the other stakeholders, collaborated in planning the concrete program, and, in doing so, created a CBPR "governance model" [66]. In this model, and based on the community members' needs and desires, we set goals for the thematic activities identified and for stakeholder collaborations for the whole program (a Swedish version of the model can be found at [64]).

Together we decided that the co-creative labs should be facilitated by local health promoters, who were also to function as bridges to the wider community. During this process, participants discussed past experiences, e.g., what created trust within the community. The community members discussed existing grassroots movements, as well as power structures, especially related to gender and ethnicity, and how these power structures influenced the community. Moreover, they brought up previous conflicts between various stakeholders, such as the fact that many earlier health-related activities had been decided by the local authorities without involving the community members in the decisions. A general lack of trust in social institutions had, therefore, led to a tendency not to use the healthcare system [61].

The participants found it important to have a multi-stakeholder perspective, but one built on the identified needs of the community members and using their place-related knowledge. A crucial aspect of the program was building trust between all the stakeholders. Having a dialogue between the members, and being self-reflective, were therefore key factors when organizing the program and the health-promotion labs. There was consensus around the decision that every stakeholder should participate on equal terms when trying to identify barriers and suggest policy changes in order to make the program work. This means, e.g., that the other members of the steering group should all be on a “horizontal level” with the community members, and learn from them as well. Thus, organizational and social structures, as well as policies, are also expected to change, at least to some extent, as a result of this program, and the ambition is that the organizations involved become more “network” oriented².

The result of these preliminary CBPR workshops was that the participants identified six areas of interest for innovations regarding health, within the framework of the three themes from 2016. The program launched thus consists of six co-creative labs, concerned with oral health (families), mental health (adults with mental problems), a safe environment (children), social health (unemployed young men), “fitness justice” (all ages and genders), and women’s health (women), respectively [64]. Surprisingly, perhaps, no major conflicts arose in this CBPR process involving all stakeholders, probably because the main agenda was set early by the community members themselves.

Participation in the co-creative labs

The activities and processes in the co-creative labs are driven by participatory principles and are led by local health promoters (or “health brokers”; [67], with the support of researchers and other stakeholders. The health promoters are employed (part-time) by some of the other stakeholders, and they all live in Lindängen. They were chosen because they turned up at the preliminary workshops and activities organized, and showed a particular interest in the program. They were then trained in participatory methods.

Each co-creative lab uses participatory methods, such as “story-telling” [68, 69], “world cafes” [69], and “research circles” [70]) that focus on the activities suggested by the groups. In these labs, the members and health promoters (and in some cases researchers and other stakeholders) meet regularly, making

space for creativity, growth, and innovation through dialogue, in order to tackle the health, and related, problems they are addressing.

The health promoters also help integrate the different co-creative labs with each other, as well as being a bridge to the larger community. The labs, thus, constitute a socio-ecological system of activities in the area, where knowledge is spread between different groups and local associations, and where participation and empowerment are expected to develop.

Outcome measures

Instead of working from a strict definition of health as an evaluative tool, we chose to be pragmatic and use a limited number of other tools. We work with focus groups with all community members participating in the labs, and with the stakeholders, and we use a guide specifically developed for CBPR projects in evaluating the planning process and the participatory interventions in the labs [66]. When using the guide, we not only discuss the participants' experiences of health in relation to the activities, but also more sensitive issues, such as power and privilege, cultural differences and trust between stakeholders, and how to determine to what extent they have changed. Moreover, other qualitative methods are used in evaluating the labs, such as dialogue cafes, storytelling, and photovoice, the latter primarily with the children [62].

A related way to determine if the program is successful is to see if levels in self-rated health have changed during the program, i.e., whether the participants think they are healthier, or feel healthier, e.g., experience reductions in depression, anxiety, or pain, or experience increased fitness, mobility, or energy levels. For this purpose, we also use the WHOQOL-BREF [71]. It primarily targets quality of life, mostly as life satisfaction, but also health, and some determinants of health and quality of life [71].

Moreover, diary notes (concerning the labs and related activities in the community) are written by some of the health promoters. And in one of the labs (fitness justice) we also look at some bio-medical factors, since the participants asked for such measures to be taken [61, 62].

² This, it turns out, was more difficult to achieve for stakeholders with a more hierarchical and vertical organization, such as the healthcare system, where the rules and regulations governing its activities were not flexible enough to benefit the program as much as expected. Other stakeholders, such as the Red Cross, were quick to learn and to adapt.

Discussion: How Praxis And Theory Might Interact

We will, in this final part of the article, briefly discuss some possible practical, theoretical, and ethical problems connected with the program.

1) One question is whether this program can achieve health *equity*. We must admit that this is uncertain, since we have no other community to compare the outcomes with. That said, we think and hope that we have approached this goal. Many positive determinants of health have been lacking in the area, and there

have previously been relatively few (real or perceived) opportunities for activities related to health. Thus, if the program is successful, which it appears to be, and health is increased in the community, it is likely that we have narrowed the health gap that exists in relation to some more fortunate groups in society, at least to some small extent. Nationally, of course, the program will not make much of a difference regarding health equity, unless the program is spread to other communities. Still, the six labs directly involve more than 300 participants from the Lindängen community, and they have children, spouses, parents, other relatives, colleagues, friends, and social networks, at home and abroad, that might be indirectly affected.

Determining how the health of the participants is affected will be a challenge, since some health effects might take years to develop. Still, using the evaluation methods and instruments described above, we expect to be able to continue to monitor changes in health, not least since this innovation is long-term and some of the stakeholders in Lindängen will keep the program going for a long time.

Importantly, even if it might be difficult directly to evaluate all the program's effects on health, we might instead find that the program has effects on the physical and social determinants of health, such as work, education (or knowledge), the environment, and social relations, or on the participants' general degree of empowerment [23]. Such changes are monitored and registered as part of the research, as well, e.g., through interviews with the health promoters every six months.

2) The program explicitly claims to work with empowerment *as a process*, giving power to the participants regarding choices and decisions. A possible problem related to such an endeavor, is illustrated by an observation that Freire made when working with disempowered groups in Brazil, namely, that people in these groups "self-deprecated" themselves [45]. This is thought to be the result of age-old oppression by the "powerful," and socialization into a subordinate role in society. Thus, hierarchies have been internalized, also by the "victims" of this "violence" [45]. As a result, some people do not experience themselves as being able to solve their own problems, but seek help in others. These others – social workers, health personnel, or researchers – might, however, though well-meaning, still reinforce the problem by not being able to overcome the "hierarchical situation" they find themselves in and that is part of the problem.

Moreover, related to this issue is a specific danger in a program such as ours, namely, that the community members hired and educated as health promoters might become part of the "establishment," and, in their new-found situation as hierarchically "above" the other community members, might start dominating them, i.e., exerting "horizontal violence" [45].

The question is, then, how do we prevent individuals working with health promotion, educated professionals or not, from becoming themselves a part of the oppressing/disempowering system? Freire's answer is, as we have seen earlier, to work together with communities with dialogue and reflection, in order to raise consciousness of the existing oppressive social structures and how they are internalized and shape our social positions. In this vein, we used storytelling in order to solve conflicts that arose [68].

In view of the social, economic, and educational differences between participants and stakeholders, it is a challenge also in this project not to reinforce oppressive social power structures and hierarchies, but, rather, to break them down, in mutual dialogue and reflection.

3) A further question, related to the former one, is this: Some theoreticians argue that power is always present in the relations between researchers and participants, and that the researchers exercise power whether they want to or not. Gaventa and Cornwall list several risks to be aware of [72:75; see also the discussion of power by 73:33 ff., and 74:21–22]. We agree that power is often exercised in programs of this kind, but hold that it is not inevitable, and that, if it is exercised, it does not have to be morally problematic [see 48].

Whether power is exercised or not depends on one's view of power. Some theoreticians seem to equate power with all kinds of influence, as when discourses are believed to govern what people think or do [e.g.75]. If such a broad definition is used, and power is taken to be unconsciously upheld by the researchers through various discourses, it is obvious that the researchers exercise power over the participants. Now, the kinds of discourses that are often criticized are those of medicine, psychiatry, and public health [75, 76], and these are not the kinds of discourses that govern this program; rather, the community's own "everyday" discourses are used to monitor the progress of the program.

However, there is another morally important question, and it is if the researchers exert "power over" the participants (other than through various kinds of scientific discourses). This would mean that they *intentionally* make the participants do or experience things that they *do not want* to do or experience [Weber in 77:2], or make them do or experience things that it is *not in their interest* to do or experience [78]. In our program, we (the researchers) have tried our best to avoid exerting power over the participants, i.e., we have not knowingly done anything against the *desires* of the participants (at least, not against those known to us), and it is hard to see that we have done things that are against the community members' interests. They have after all been the drivers of the whole process.

Other forms of "social power" might be exercised in projects of this kind – forms that do not, e.g., involve coercion, manipulation, or force, and do not qualify as "power over." These would include intentional influences that people freely accept, such as when the community members in Lindängen were convinced through information to participate in the preliminary workshops of the program.

Thus, in a very general sense, the researchers do exert some social power, namely, by facilitating for people to become more empowered and healthier. This is hardly morally controversial. Notice, however, that even if the ideals are highly set, researchers might still fail to reach them. Self-reflexivity, and "cultural humility" [79:316], are therefore integral parts of this whole enterprise.

4) We have chosen, and argued for, a participatory approach, because we think that creating empowerment processes works better with problems of the kind addressed by this program than "traditional" methods. Participation is also preferable when evaluating the program, since the critical scrutiny of the program by those affected by it is paramount. Wallerstein's guide is therefore, as

mentioned, a key tool for our scientific evaluation [66]. This means that progress in the labs was primarily evaluated using qualitative tools. However, some more traditional methods are compatible with the chosen approach [80], and this program also uses interviews, and statistical data (from the WHOQOL-BREF), but collected and analyzed in accordance with the general participatory guidelines.

Thus, there are different degrees of community participation in the research performed. Some of the research is traditional, in the sense that it involves interviews with participants that are then analyzed by the researchers themselves. This, for example, goes for a study about the experiences of the steering group and the secretariat [62].

However, the community participants have, within their specific labs, decided on research questions in planning their own activities. Moreover, in one lab the community members have themselves been trained to analyze the data concerning their work. The diaries written by the health promoters will, furthermore, be analyzed in collaboration with them. Apart from the scientific publications written by the researchers themselves, some participants, primarily the health promoters, will write and publish reports about their work in non-scientific fora.

Conclusion

In this paper, we have presented a CBPR program initiated in a so-called vulnerable area in a major city in the south of Sweden. We have also described a number of theoretical tools that govern and motivate the program. And we have, finally, problematized and discussed some theoretical assumptions in relation to the practice of CBPR.

No outcomes have been presented in the paper, since its purpose was to give an overview of the project and the theoretical foundation for it. Some of the evaluation studies are completed, while others are underway. The outcomes are promising, so far, and in several ways the program appears successful.³

³ A final note: The covid pandemic that began early in 2020 has partly halted the work in the different labs. Some research has, however, still been accomplished during this time, primarily with the help of digital media.

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Ethics approval: Not applicable

Consent to publication: Not applicable

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Competing interest: The authors declare no conflicts of interest.

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