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ORIGINAL ARTICLE

Empowerment Praxis: Community Organizing to Redress Systemic Health Disparities

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Abstract Social and environmental determinants of childhood obesity present a public health dilemma, particularly in low-income communities of color. Case studies of two community-based organizations participating in the Robert Wood Johnson Foundation's Communities Creating Healthy Environments (CCHE) childhood obesity initiative demonstrate multilevel, culturally situated community organizing strategies to address the root causes of this public health disparity. Informed by a 3-lens prescription—Social Justice, Culture-Place, and Organizational Capacity—contained in the CCHE Change Model and Evaluation Frame, we present examples of individual, organizational, and community empowerment to redress systemic inequities that manifest in poor health outcomes for people of color. These case studies offer compelling evidence that public health disparities in these communities may effectively be abated through strategies that employ bottom-up, community-level approaches for (a) identifying proximal and distal determinants of public health disparities, and (b) empowering communities to directly redress these inequities. Guided by this ecological framework, application of the CCHE evaluation approach demonstrated the necessity to document the granularity of community organizing for community health, adding to the community psychology literature on empowering processes and outcomes.

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Introduction

Systemic social and environmental inequities frequently manifest in a variety of disproportionate health outcomes, including uneven rates of childhood obesity. This is particularly the case in low-income communities of color (Borrell, Pons-Vigués, Morrison & Díez, 2013; Gordon-Larsen, Nelson, Page & Popkin, 2006; Sallis, Floyd, Rodríguez & Saelens, 2012). These inequities represent social and environmental indicators of a widening race and class health gap (Bleich, Jarlenski, Bell & LaVeist, 2012; Link & Phelan, 1995; Phelan, Link & Tehranifar, 2010), which often results from proximal and distal health determinants such as recreational and socioeconomic inequality (Grills et al., 2014; Gordon-Larsen et al., 2006; Merzel & D'Afflitti, 1971; Sallis et al., 2012). However, there is increasing evidence that this gap may be mitigated using community empowerment approaches (Campbell & Murray, 2004; Friel & Marmot, 2011; Griffith et al., 2010; Speer, Tesdahl & Ayers, 2014). Community psychology has argued for community empowerment strategies that leverage structural power to achieve psychosocial changes that address the social and environmental determinants of health inequities (Shinn, 2015; Speer & Hughey, 1995; Trickett, 2009; Zimmerman, 2000).

Community Organizing for Public Health Promotion

A growing body of literature suggests community organizing is a potentially impactful community empowerment strategy for developing and implementing targeted public

health prevention and promotion programs (De Souza, 2009; Gonzalez, Villanueva, & Grills, 2012, 2014; Sandoval & Cáceres, 2013; Speer et al., 2014). Community organizing refers to a process that "engages people, organizations, and communities toward the goal of increased individual and community control, political efficacy, improved quality of life, and social justice" (Orr, 2007, p. 2). In contrast to traditional public health approaches for reducing health disparities that focus primarily on changing individual health behaviors—creating minimal sustained community-level impact (Campbell & Murray, 2004; Speer & Christens, 2012)—community organizing engenders community efficacy to (a) address the underlying systemic inequities that cause these health disparities, and (b) promote sustained structural changes that create more opportunities for individuals to make healthier behavioral choices (Gonzalez et al. 2012; Speer et al., 2014; Taber, 2011).

Community organizing is a collaborative process that engages, educates, mobilizes, and unites oppressed and marginalized residents, local organizations, and key stakeholders in strategic, collective efforts to gain voice, power, and influence within their communities, and effect social and environmental change such as culturally relevant, community-based health promotion (Cheezum et al., 2013; Minkler & Wallerstein, 2012; Speer et al., 2014). In this process, community organizing is concerned with engaging community members across geographical scales —e.g., cities, towns, and neighborhoods—to (a) build relationships, (b) identify community concerns, (c) increase individual and community awareness and understanding of these concerns (Freire, 2000), and (d) promote strategic, collaborative action addressing collective interests by engaging decision-makers across public and private sectors. The overarching goal of community organizing for health promotion is to empower communities by building their social, political, economic, and decision-making capacities to effect social and environmental change—e.g., change in the built environment—reflecting the community's health priorities (Minkler & Wallerstein, 2012; Obama, 2008; Orr, 2007; Speer et al., 2014). This process stands in contrast to the prevailing approach in public health prevention and promotion, which seeks to adapt individuals to conditions that have been produced through decades of public disinvestment, resulting in multiple proximal and distal determinants of health disparities in low-income communities of color (Campbell & Murray, 2004; Speer & Christens, 2012; Trickett, 2009).

Empowerment Theory—Community Organizing for Public Health Promotion

Empowerment theory (Rappaport, 1987) informs community organizing for health promotion by providing principles and a framework (Zimmerman, 2000) to understand the processes and consequences of residents' efforts to exert control over macro-level decisions that affect their lives. These decisions shift the frame of analysis from the individual to that of the larger social and political structures affecting individual-level processes and functioning, thus emphasizing the linkages between community capabilities for engaging in healthy activities, for example, and the affordances of social and environmental settings. In the context of public health, empowerment is hinged on individual and collective agency in redefining settings to encourage community health capabilities (Shinn, 2015). Thus, empowerment inherently concerns social difference, mirroring the methodological lens of diffraction, which extends the critical reflexivity of community psychology by accounting for social difference and the ontological and epistemological "effects those differences have within the world" (Langhout, 2016, p. 4). Community organizing for public health, grounded in community empowerment, embraces diffraction through an iterative approach to collective agitation for social and environmental change by a diverse set of social groups. This complements empowerment theory's conceptual shift of community health away from the dominant Western paradigm fixated on individual blame (Rappaport, 1987) toward an emphasis on community health as a dynamic that is situated at multiple levels of analysis (e.g., microsystems, mesosystems, and macrosystems) (Bronfenbrenner, 1977; Speer et al., 2014; Trickett, 2009).

The core of empowerment theory emphasizes control over macro-level decisions across mutually interdependent individual, organizational, and community domains (Christens, 2012; Christens, Inzeo & Faust, 2014; Lawrence-Jacobson, 2006; Speer & Hughey, 1995; Zimmerman, 2000) in which people, organizations, and communities claim voice and control over their social and physical circumstances (Freire, 2000; Griffith et al., 2010; Prilleltensky & Prilleltensky, 2006; Rappaport, 1987). At the individual level, empowerment manifests in the individual's ability to contribute to the "process" of developing organizational power—through organizational membership, relationship building, action, and reflection —and in "outcomes" of social and environmental change —e.g., actions and demands emerging out of a newly found knowledge of power, social and emotional connectedness, and organizational participation (Christens et al., 2014; Speer & Hughey, 1995; Zimmerman, 2000). At the organizational level, processes of empowerment manifest in multiple and dynamically interrelated modes of participation such as building relationships among organizations with aligned motives and interests, and developing and enacting ongoing community organizing actions. Outcomes at this level might include organizational ability to

mobilize a constituent base, shape topics for debate, influence discussions within the public arena, and shape community ideologies (Griffith et al., 2010; Speer & Hughey, 1995; Zimmerman, 2000). At the community level, empowerment processes include developing connections between institutions such as schools, law enforcement, private businesses, and the local community and fostering these connections to take collective action (e.g., developing safe play spaces for children in communities plagued with obesity and chronic disease). Outcomes at this level include a host of empowered organizations in communities brought together to collectively address social and environmental inequities that harm community health (Griffith et al., 2010; Rasmus, Charles & Mohatt, 2014; Speer & Hughey, 1995; Zimmerman, 2000).

Given these inputs, empowerment theory informs community organizing toward public health by situating an understanding of organizing processes and outcomes in the context of developing the influence and power of affected communities. In doing so, communities of practice may further recognize the necessity for ground-up, community-based solutions for health equity involving persons from different social groups—e.g., social class, gender, ethnocultural diversity—collaboratively questioning social and environmental circumstances, advocating for progressive reform.

The purpose of this paper is to inform individual, organizational, and community empowerment to redress systemic inequities that manifest in poor health outcomes for people of color by (a) introducing the novel Communities Creating Healthy Environments (CCHE) Change Model and Evaluation Frame for understanding and explaining community organizing as a community health promotion strategy involving persons from various social groups in disparate settings, (b) illustrating the processes and outcomes of two community-based organizations evaluated using this evaluation frame, and (c) arguing for a contextual, culturally relevant, and pragmatic community organizing approach within public health.

Communities Creating Healthy Environments Initiative and Community Organizing Change Model and Evaluation Frame

The CCHE initiative aimed to address proximal and distal determinants of childhood obesity in low-income communities of color through community organizing focused on organizational capacity building and community empowerment. CCHE presents a seminal case of the increasing emphasis on establishing community partnerships grounded in culturally situated strategies for effecting social and environmental change through community organizing and capacity building (e.g., Gonzalez & Trickett, 2014; Rasmus et al., 2014; Trickett, 2009). In order to evaluate the potential of community organizing and policy advocacy toward redressing childhood obesity, 21 CCHE grantees representing four major racial/ethnic groups (African-American, Asian and Pacific Islander, Latino/a, and Native American) located in 16 cities and indigenous nations across four geographic regions (West, Midwest, South, Northeast) were selected for participation in the Robert Wood Johnson Foundation (RWJF)-funded CCHE initiative. Each grantee worked with their existing community, leaders, and ally base to develop and implement a childhood obesity campaign strategy. A three-lens prescription—Social Justice, Culture-Place, and Organizational Capacity-Organizing Approach—developed by the CCHE evaluation team and vetted by CCHE partners informed community organizing strategies by accounting for (a) grantee social justice perspectives (e.g., civil rights, health justice), (b) the culture place of each locale (i.e., cultural and geographical makeup of an area), and (c) grantee organizational capacity-organizing approach (i.e., place-based, culturally relevant community organizing approaches amendable to grantee organizational capacity) (Subica et al., 2016).

Communities Creating Healthy Environments organizing approaches consist of five overarching strategies (Table 1) grounded in individual, organizational, and community empowerment processes and outcomes. These strategies were integrated into the evaluation frame in order to analyze the processes and outcomes of community organizing toward redressing childhood obesity in low-income communities of color. Each case study highlights the organizations' employment of these strategies and the resultant individual, organizational, and community processes and outcomes.

Case Studies of Community Organizing to Promote Community Health

Guided by the Praxis Group (a national non-profit organization and program office for CCHE), CCHE grantees, with support from the CCHE technical assistance team, employed participatory processes including a range of ethnoculturally diverse community members across social classes in different settings to identify and refine organizing strategies (Grills et al., 2014) amenable to the "open-ended, unpredictable processes" (Cornish, Montenegro, van Reisen, Zaka & Sevitt, 2014, p. 61) characteristic of community organizing. CCHE grantees used a common set of organizing principles, strategies, and tactics that have emerged from decades of community organizing experience including outreach, organizing skills training, networking, and alliance building (e.g., Alinsky, 1971).

Table 1 Communities creating healthy environments community organizing strategies and analysis framework

Growing community base • Adult engagement • Youth engagement • Door-to-Door canvassing • Base expansion • Geographic expansion	Developing a community base sympathetic to, and supportive of, public health change initiatives is a key organizing strategy (Alinsky, 1971; Speer et al., 2014). Given this, growing community base was identified by CCHE partners as an effective strategy to produce health equity in afflicted communities.
Building leader base • Political education • Event planning • Event leading	Community leaders are central actors in public health change initiatives that need to be developed by community-based organizations (Alinsky, 1971; Christens, 2012; Minkler & Wallerstein, 2012). As a fundamental organizing principle, CCHE partners provided training in the form of workshops, conferences, and seminars to build a skilled, well-informed leader base.
Building ally base • Ally involvement • Strategic relationship • Shared goals	Community change initiatives are most effective when supported by an aligned base of organizational allies with shared interests and values poised to work together toward community health equity (Alinsky, 1971; Mizrahi, 1999). CCHE partners strategically built their ally base building as a critical organizing strategy.
Message reframing • Popular education • CBPR	To build on the preceding community organizing strategies, CCHE partners argued that achieving ground-up community health equity would be challenging without reframing resident understanding of the true, root causes of childhood obesity and broader health inequities in low-income communities of color (Freire, 2000; Grills et al., 2014). As such, partnering organizations worked to develop messages that explicated systemic inequities as precursors to public health disparities.
Mobilizing base • Attended town hall meeting • Attended rally	Organizational ability to activate and maintain ongoing community base participation in public health initiatives was employed by CCHE partners as a fundamental activity of community organizing for achieving community change (Alinsky, 1971; Minkler & Wallerstein, 2012).

These strategies and tactics were employed to address childhood obesity according to community needs and reframe dominant individual blame health narratives. Consistent with the methodological lens of diffraction (Langhout, 2016), the following cases were selected to illustrate collaboration by people of different social class and racial identities advocating for public health equity in disparate geographic and cultural settings.

Case Study Methodology

The CCHE evaluation team conducted a community-based participatory research (CBPR) evaluation of the CCHE initiative, using quantitative and qualitative methods guided by the CCHE Change Model and Evaluation Frame. All grantee data for the following case studies were collected between October 2010 and October 2013. Case studies for each grantee were based on data from (a) 12 quarterly structured interviews, (b) 1–2 days of semi-structured observations, (c) one grant cycle termination closeout interview, (d) one 6-month post-grant interview, and (e) administrative data. The quarterly structured interviews were conducted every 3 months throughout the grant period by the evaluation team via telephone or in-person. These 23-item interviews included quantitative and qualitative questions designed to document grantee community organizing processes and outcomes. The semi-structured observations were conducted over the course of 1–2 days at each grantee site to gain insight into organizing campaign objectives and to develop an understanding of community contextual conditions. The closeout and 6-month post-grant interviews consisted of an eight-item semi-structured interview designed to assess end-of-grant and post-funding community organizing outcomes. Self-report data were vetted via exhaustive review of all available organizational documents, public records, and other sources such as print media.

All quantitative quarterly structured interview data were categorized according to the CCHE Community Organizing Strategies Framework (Table 1) and entered into IBM SPSS v. 22 to track base numbers and frequency of organizing activities (e.g., growing community base). In addition, all qualitative data from the structured quarterly interviews, semi-structured observations, and closeout and 6-month post-grant interviews were transcribed and entered into ATLAS.ti version 5.5 and coded according to the organizing strategies framework, with sub-codes related to each organizing strategy (e.g., ally involvement, adult engagement, and political education) (Table 1). Interrater reliability (involving independent ratings by three raters) was conducted with Fleiss' kappa (Fleiss, 1971) to resolve any coding discrepancies via team review. Kappa was calculated to be .71, which indicated significant rater agreement. Sampling ceased following 6-month post-grant interviews, as thematic analysis indicated sample saturation (Guest, Bunce & Johnson, 2006). Consistent with the tenets of CBPR, summary reports and case studies reflecting the content of this paper were vetted by CCHE community partners for accuracy.

Power U Center for Social Change (Power U)

Social Justice and Culture-Place Lens

The Power U Center for Social Change (Power U) organizes several Miami low-income communities of color to combat institutional oppression through leadership development, promotion of self-determination, and building community power. For the CCHE initiative, Power U sought to redress social and environmental conditions contributing to infant mortality and childhood obesity in the Miami-Dade County communities of Overtown and Opa-Locka. These historically Caribbean and African-American communities that cover 1.50 and 4.2 square miles, are comprised of 14,094 (approximately 90% Black or African-American) (U.S. Census Bureau, 2000/2010) and 15,219 persons (approximately 66% Black or African-American) (U.S. Census Bureau, 2000/2010), and have extreme rates of family poverty—49% and 39%, respectively (U.S. Census Bureau, 2000/2010). They also demonstrate elevated prevalence of infant mortality, low birth weight, and high-risk births due to inadequate natal and prenatal care (Florida Memorial University, 2010; Healthy Start Coalition, 2008). Working with a base of mothers concerned about local hospitals distributing "free formula with formula companies" (Power U Organizer), Power U identified these demographic markers and community-identified hospital practices as key indicators of uneven children's health outcomes in Miami-Dade county's low-income communities of color. Because breastfeeding is an empirically supported childhood obesity prevention measure (Arenz, Rucker, Koletzko, & von Kries, 2004), Power U and their base sought to organize new and expectant mothers to reframe the prevailing myth that "formula is best" (Power U Organizer) and challenge local private hospitals that serve their communities to implement policies eliminating formula distribution and increasing breastfeeding service accessibility "as a means of reducing infant mortality and illnesses including diabetes and childhood obesity" (Milner, 2013, p. 4).

Organizational Capacity-Organizing Approach Lens

Power U worked directly with Black new and expectant mothers in the Overtown and Opa-Locka communities, "visioning what a Black-led reproductive justice campaign looks like in Miami" (Power U Organizer). A Power U organizer expressed that it would be vital to "ensure that breastfeeding is actually a priority [in hospitals] and not pushing baby formula on mom[s], which has been traditionally happening in hospitals, especially at Jackson [Health System]." Accordingly, Power U explored community interest in the Baby-Friendly Hospital Initiative (BFHI)—a global World Health Organization (WHO) and United Nations Children's Fund (UNICEF) initiative designed to encourage healthy infant feeding and mother–child bonding practices, offering "Baby-Friendly" designation to participating hospitals—and the national "Ban the Bags" initiative targeting hospital participation in infant formula distribution. Because policy change needed to be grounded in grassroots action, Power U's organizers used action research, door-to-door canvassing, and personal outreach to engage women in conversations about their experiences of hospital natal and prenatal care and the importance of breastfeeding, affording individual empowerment through knowledge of birth, reproductive, and racial justice. This approach also emphasized the importance of making Miami-Dade County "Baby-Friendly" with a designation process, which Power U and their constituency identified as an approach to introduce "policies to ensure and prioritize the health of moms and babies" (Power U Organizer). They were able to provide indirect but clear linkages between formula feeding and childhood obesity, which agreed with the Arenz et al. (2004) meta-analysis suggesting that breastfeeding significantly reduces childhood obesity. Their organizing strategy provided a method to *grow a community base* of new and expectant mothers from 4 to 35 mothers over the course of the campaign. This empowered Power U at the organizational level to elicit critical interest, knowledge, and support in their constituency, enabling them to identify community leaders committed to organizing for equitable hospital policies and breastfeeding support in Overtown and Opa-Locka. Identifying a need to build their capacity to support this initiative, Power U hired a lead organizer experienced in racial justice and health care organizing, a licensed midwife to provide child birthing classes, and worked with WIC to provide additional nutrition and breastfeeding education and support to their base.

Power U provided political education and reproductive justice classes to develop mothers as champions—i.e., community leaders—who then advocated for hospitals to improve their policies and practices. *Building a leader base* involved classes on campaign planning, identifying uneven natal and prenatal care practices in local hospitals, and leadership development. In a key example of this, a community leader and mother said, "I had no idea what that was [reproductive justice], until I came into the [child birthing] classes and they taught me that we do have rights, we do have a say so, we are a part of this earth, and we have massive power and authority to speak out about our health." As a result of these culturally situated trainings, this group of concerned mothers in the community ascended to the role of community leaders empowered to independently facilitate fundraising meetings, plan events, conduct community-based research with academic partners, and advocate for equitable hospital natal and prenatal policies and practices. While Power U was already working with a cadre of leaders

organizing around a range of initiatives, 10 dedicated leaders educated and empowered to participate in, and lead, a host of activities, including community-based participatory research, focused on access to BFHI came to the fore of the CCHE campaign. The work of Power U's community leaders concerning women's reproductive rights extended individual and organizational empowerment through active and ongoing community participation, co-production of knowledge, and the organizational ability to mobilize their base. Furthermore, these leadership development activities enabled Power U community leaders to work with Power U and affiliated organizations (including local media outlets) to hold private hospitals accountable for inequitable access to BFHI services in low-income communities of color.

Power U also identified *building ally base* as a key organizational empowerment strategy for increasing collective voice, power, and resources and pushing forward their birth justice vision and policy recommendations. Power U developed relationships and collaborative partnerships with organizations, many having similar values and interests, more than doubling their ally base from 7 to 15 over the course of the campaign. They worked extensively with community-based partners to educate and empower their base on issues related to birthing options, healthy and safe environments for raising children, and assisting with events and base building. For example, Florida Legal Services helped to identify policy goals, access legal records and research, and organize Town Hall meetings. The MiLola South Florida Taskforce helped facilitate campaign activities including identifying other reproductive justice communities. Healthy Start Coalition monitored outcomes of BFHI hospitals and provided lactation training to their community base. Through a strategic increase in alliances that mutually shared a concern with BFHI services, Power U and their community and leader base were empowered at individual, organizational, and community levels, extending their collective ability to advocate for equitable hospital policies and breastfeeding support.

Power U collaborated with their growing base of community members, leaders, and allies in *message reframing* —reshaping the narrative about the causes of childhood obesity from individual/family lifestyle choices related to breastfeeding, to one grounded in the broader ecological position that "breastfeeding is not just a lifestyle choice but a public health, reproductive justice and racial issue" (Milner, 2013, p. 6). In collaboration with their leader and ally base, Power U employed liberatory, popular education, and action to reframe community perceptions of the relationship between breastfeeding and reproductive justice via child birthing classes, critical race education, reproductive justice workshops, and community discussions of child birthing experiences. Another approach included lactation consultation training for leaders and community members, which served the dual purpose of providing breastfeeding education and employment.

Community leaders actively conducted community-based participatory survey research with 300 participants designed to collect "information on what your experiences with breastfeeding [are] and really more importantly getting information on what kind of breast feeding [education] was being offered" (Power U Organizer). An important finding of this research was that it confirmed community member feedback that hospitals were distributing formula bags at patient discharge. Furthermore, Power U's promotion of BFHI and breastfeeding benefits aligned with community survey findings. Participating in the survey also helped mothers take the time to reflect on their past birthing experiences in local hospitals, empowering them at the individual level and shifting their consciousness toward challenging the prevailing myth around formula feeding without Power U leaders "shaming and blaming" (Power U Organizer) mothers once they disclosed they had never breastfed their children. "The survey was a really important tool because it really got mothers to start thinking about breast feeding in a serious way; just hearing mothers talk about how nobody [in the hospital] asks them if they should feed their baby formula for their first feeding, and then explaining, 'Moms, you know, in California the policy is that you have to give informal consent to feed the baby formula'" (Power U Organizer). Furthermore, the survey results became a powerful tool for change—as one Power U staff organizer noted, "we were able to write a report called *A Call For Birth Justice in Miami*, where we used the survey results to make policy recommendations of what needed to happen. We had the evidence, so that was really important." The production of this report, which was viewed over 1500 times on Power U's website, was instrumental in reframing the dominant understanding of reproductive and birth justice.

With empirically supported knowledge of inequitable access to BFHI services and a growing community and ally base, Power U was empowered at the organizational level to *mobilize their base*, advocating for "Ban the Bags" policies. Community members, leaders, and allies attended Town Hall meetings, presenting survey data and community demands to decision-makers. They built awareness about constituent reproductive justice issues in Miami-Dade County and attended rallies advocating for women's rights. This process empowered the community —i.e., Power U, community members, leaders, and partnering organizations—to demand reproductive and birth justice in Opa-Locka and Overtown, highlighting their collaboration in achieving pivotal policy wins including

"getting Jackson Health System to promote breastfeeding and stop handing out commercially sponsored infant formula samples" (Praxis).

CAAAV Organizing Asian Communities (CAAAV)

Social Justice and Culture-Place Lens

CAAAV Organizing Asian Communities (CAAAV) works with New York City's Asian immigrant and refugee communities to address issues of local and national significance including immigration, workers' rights, housing, public health, education, and language access through community organizing, advocacy, and leadership development. For the CCHE initiative, CAAAV focused on reclaiming a rapidly gentrifying New York City Chinatown by identifying and addressing inequitable zoning practices. CAAAV recognized this as an effective method for addressing living conditions that impacted childhood obesity and wider health issues—e.g., stress and hypertension—including access to healthy food and recreational space.

Childhood obesity is an increasing concern in New York City's Chinese and Chinese-American communities. Extant data indicate 24.6% of Chinese-Americans between 6 and 19 years of age in New York City are overweight or obese. U.S.-born Chinese-American boys aged 6–12 have a combined overweight/obesity rate of 40% (Au, Kwong, Chou, Tso & Wong, 2009). This growing epidemic is highlighted by the reality that Chinatown—an area of 2 square miles with a population of 150,000 residents—is being gentrified, further limiting access to recreational space due to overdevelopment and marginalizing access to culturally appropriate, fresh, and healthy foods from local, Chinese-owned, small-scale food markets.

According to the U.S. Census Bureau (2000/2010), the median household income for Asian groups in Chinatown is $29,525 compared to non-Hispanic Whites at $58,265. As New York City rents skyrocket, families are increasingly forced into overcrowded apartments and small, local businesses are closing—"I think that you can't separate poverty from childhood obesity or health problems. I think there's an issue of stressors for families, certainly in a community like Chinatown." (CAAAV Organizer). Given these circumstances, CAAAV's CCHE efforts addressed perceived proximal and distal determinants of childhood obesity by targeting zoning policies and illegal, discriminatory landlord practices in NYC's Chinatown, which displaces Asian-American residents and small businesses in favor of luxury housing, hotels, and large businesses, making what was once an affordable, healthy place to live for Chinese and Chinese-Americans less accessible. "If the small businesses in Chinatown are displaced, which a big piece of the rezoning campaign is reserving those for small businesses, then people wouldn't have the same access to affordable food and produce that they have already" (CAAAV Organizer).

Organizational Capacity-Organizing Approach Lens

Due to community concerns regarding gentrification, CAAAV worked with their existing leader base to inform the Chinatown community about inequities produced through uneven zoning practices creating poor housing conditions and a diminishing cultural hub for New York City's Chinese and Chinese-American communities. Their strategy for *growing community base* reflected processes of individual empowerment including canvassing residents door-to-door, building-to-building to educate community members about the effects of inequitable zoning practices and how they could collaboratively address these practices. This was a critical step to growing a base of residents "who are engaged in the work that you are doing [sic]" (CAAAV Organizer). Individual and organizational empowerment was extended by growing their community base from 200 to 377 members by appealing to community members most affected by inequitable zoning policies. CAAAV also supported individual processes of empowerment by confirming the concerns of community members and affording a space for the community to collectively voice these concerns. Increased community alignment with, and participation in, CAAAV empowered the organization through new and expanded modes of community involvement. As a result, CAAAV was able to identify and develop leaders through political education and advocacy initiatives.

CAAAV focused on *building leader base* by empowering community residents and youth at the individual level to participate in policy campaigns. "We have been doing a lot of leadership development and it has been very time consuming, but it has been very worthwhile. I almost feel like we cannot do enough in political education with people about this because people will forget or things change" (CAAAV Organizer). Their primary leadership development strategy included monthly meetings, whereby leaders learned about housing and rezoning issues affecting Chinatown (e.g., closure of community-based supermarkets and building of luxury complexes) and participated in developing recommendations for a zoning plan that placed height restrictions on new developments and preserved rights for existing tenants. In this process, CAAAV increased their leader base from 4 to 47. "We've been doing much more rezoning work in the past

6 months, especially in terms of leadership engagement, so that's what you can attribute the growth in numbers to" (CAAAV Organizer). These activities led to resident individual empowerment outcomes including increased knowledge concerning the linkages between zoning policies and childhood obesity, and advocacy skills to promote community engagement and resiliency.

CAAAV's *building ally base* strategy focused on working with the Chinatown Working Group (CWG)—a collective of community-based organizations, community boards, developers, and community members—which was a critical process toward organizational empowerment. CAAAV's efforts resulted in an increase in their ally base, from one to five ongoing allies over the course of the campaign. One example of CAAAV's partnership with the CWG to improve community health outcomes was advocating for community participation in the rezoning process, and amplifying the interests and voice of the community. In another example, CAAAV's community, leader, and ally base advocated for, and won, tenant association voting rights in the CWG, which increased Chinatown resident participation in local governance. "That is really critical, because from my understanding this is the first zoning campaign where city planning really does look into community boards for input on these proposals" (CAAAV Organizer). As such, greater community empowerment emerged out of this new partnership, positioning them to take collective action to preserve affordable housing and tenant rights.

By engaging in popular education, CAAAV and their base agreed that it would benefit their organizing efforts if they turned complex zoning language into a language that was accessible to all stakeholders. Given this, CAAAV engaged in *message reframing,* disseminating informational materials explaining the zoning process and tenant rights to community residents, CWG partnering organizations, and policy makers, describing the deleterious effects of inequitable rezoning and housing policies on Chinatown resident quality of life. These collective actions empowered CAAAV and their community partners at organizational and community levels to inform and shape the public discussion of zoning and tenant rights. They were able to increase community awareness of systemic inequities that yield poor housing conditions and restrict access to greenspace and healthy food, producing poor health outcomes. As a result, community members leveraged their knowledge of inequitable zoning policies to stake a claim in Chinatown's development.

CAAAV also published multiple newsletters and postcards to disseminate their reframed message. They published all materials in Chinese and English and for certain materials, also in Spanish. Furthermore, CAAAV and the Chinatown community were well represented within public discourse and decision-making. Resident leaders spoke at community and ally meetings advocating for CAAAV policies at the Department of City Planning, City Council, Community Board, and New York City Housing Authority meetings. Along with their leaders and ally base, CAAAV reached out to Chinese and American media in New York City and collaboratively published white papers with their ally base.

Given the multifaceted organizing strategies that CAAAV employed, CAAAV was empowered at the organizational and community levels to *mobilize a base* of well-informed community members, leaders, and allies to organize against inequitable zoning policies in New York City's Chinatown. This included base member participation in community meetings and town halls, political education activities, and social events. Central to this, though, was member attendance at community meetings and town halls to voice community concerns at public forums and display organizational and community power. In a close-out interview, CAAAV's lead organizer noted: "A lot of our work at that time was giving feedback on the [CWG rezoning] plan, but also showing up to these meetings and showing the power of low-income tenants and pushing the plan to be a better plan and not letting it just be about tenants' home interests or landlord interests, but specifically Chinatown low-income interests." CAAAV members also participated in writing memos, monthly newsletters, brochures, and educational materials related to rezoning and the need to preserve Chinatown. Representation at Town Hall and CWG rezoning meetings proved to be a productive way to advocate for tenant rights, ultimately leading to promising outcomes including a commitment to increase "public recreational space for Chinatown residents along the increasingly gentrified Lower East Side waterfront" (Praxis).

Summary

In sum, Power U and CAAAV represent examples of multilevel, community-based, and culturally situated interventions that employed community organizing strategies to empower individuals, organizations, and communities, and promote health through systems change. These organizations worked in disparate contextual circumstances—Black-Caribbean new and expectant mothers in Miami-Dade County and Chinese and Chinese-Americans in New York City—with divergent processes that equally led to local policy changes. Power U and their community, leaders, and ally base achieved two policy wins—three target hospitals in Miami-Dade County "banned the bag" and committed to adopting BFHI practices and Jackson Health System administrators committed to adopting a

system wide "Ban the Bags" policy and beginning the "Baby-Friendly" designation process. CAAAV—in coordination with their community, leader, and ally base—achieved two policy wins including CWG incorporation of anti-demolition and anti-harassment protections into the Chinatown rezoning plan and a commitment to developing a recreation center in the community.

Discussion

Public health disparities in low-income communities of color may effectively be abated through strategies that employ bottom-up, community-level approaches for (a) identifying proximal and distal determinants of public health disparities, and (b) empowering communities to directly redress these inequities. While these strategies may be unconventional within the dominant approach to public health, community psychology, with its ecological perspective and emphasis on attending to the salience of cultural and contextual factors (Trickett, 2009), can advance a community-level understanding of proximal and distal determinants of public health disparities and processes for mitigating them. Community-based strategies in public health have employed bottom-up approaches. However, they often ignore systemic inequities that manifest in social and environmental health disparities, which are often referred to by community organizers as the root causes of social health disparities and inequities. To combat these 'root causes,' the CCHE case studies offer compelling evidence supporting the effectiveness of implementing health promotion grounded in the art and science of community organizing. Specifically, community-based organizations and partnering agencies might consider incorporating culturally situated community organizing strategies that challenge systemic inequities through community engagement, leadership development, alliances, and message reframing that incorporates systemic/structural factors that impinge upon individual and community health.

Informed by the three-lens prescription—Social Justice, Culture-Place, and Organizational Capacity-Organizing Approach—and analyzed through the CCHE evaluation frame, the nuances and gradations of community organizing effort and change in the socially and environmentally diverse communities of Power U and CAAAV's were methodically captured. These case studies used the CCHE evaluation frame inclusive of five community organizing strategies, providing a flexible, culturally situated methodology for capturing the richness and complexity of community organizing for public health equity. As such, these case studies provide insights into "making science out of collaboration and how it influences community process and outcome" (Trickett, 2009, p. 264) concerning the multilevel interventions presented by Trickett (e.g., developing a nuanced conception of the community and attending to culture and context).

Inspired by such ecological perspectives, the evaluation approach was motivated by the necessity to document the granularity of community organizing for community health, adding to the community psychology literature on empowering processes and outcomes, such as organizational membership and knowledge of power (Speer & Hughey, 1995; Zimmerman, 2000), accounting for collective power harnessed across a diverse range of social groups noted in diffraction (Langhout, 2016), and flexible approaches affording multilevel, community-based, culturally situated methods for producing social and environmental change (Gonzalez & Trickett, 2014; Rasmus et al., 2014; Trickett, 2009). The CCHE evaluation frame provides a step toward capturing the "open-ended, unpredictable processes" (Cornish et al., 2014, p. 61) of community organizing by identifying, delineating, and systematically tracking these five overarching community-organizing strategies informed by the three-lens prescription. By evaluating these strategies, it is possible to explicate the nuances of individual, organizational, and community empowerment promoted by multilevel, culturally situated interventions. Such analyses provide an understanding that the processes of community organizing are not fixed; rather, they are dynamically negotiated, evolving processes guided by the social, political (Prilleltensky & Prilleltensky, 2006; Zimmerman, 2000), cultural, and place-based context in affected communities (Grills et al., 2014). In addition, they align with the literature on community organizing, the social change objectives of social justice focused community-based organizations, and the interests of disenfranchised communities (Campbell & Murray, 2004; Cheezum et al. 2013; De Souza, 2009; Gonzalez et al. 2012; Grills et al., 2012; Grills et al., 2014; Minkler & Wallerstein, 2012; Obama, 2012; Sandoval & Cáceres, 2013; Speer & Christens, 2012; Speer et al., 2014; Taber, 2011).

It is noteworthy that Power U and CAAAV, while utilizing similar community organizing strategies, achieved unique individual, organizational, and community-level empowerment outcomes with differing communities, leaders, and ally bases. While community organizing practices and principles emphasize the importance of a strong community base (Alinsky, 1971), these CCHE case studies suggest coordinating a range of organizing strategies—e.g., developing leader and ally base, message reframing, and mobilizing base—situated within a three-lens prescription (Subica et al., 2016) may be harnessed to empower communities that have varying community base numbers. This is particularly promising given situational community and organizational capacities. Coordinated

strategies within culturally situated, place-based frameworks, per the CCHE model, can yield important shifts in base numbers, allies, and policy changes that can empower communities and support the promotion of community health.

Perspectives and approaches in community psychology such as the liberatory practices identified by Watts and Flanagan (2007) and the methodological approach of diffraction (Langhout, 2016) can be useful, particularly considering the multiple levels of analysis associated with the processes and outcomes of community organizing for public health prevention and promotion. Empowerment theory dovetailed by liberatory practices—e.g., message reframing—involving people of different social classes and identities provides an opportunity to capture the nuances of community organizing, reframing perceptions of the root causes of public health disparities. Within this context, communities of practice may consider individual, organizational, and collective empowerment as viable strategies to redress public health inequities. In parallel, communities of practice must also begin to demonstrate the liberatory processes inherent in organizing for community empowerment, which teach us to be critical of structural inequities (Watts & Flanagan, 2007), ultimately reframing individual, community, and institutional awareness of how uneven social and environmental realities are produced and reproduced to the disservice of community health.

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