LET'S TALK: REDISTRIBUTING POWER TO ADVANCE HEALTH EQUITY

SUPPLEMENT 3 – ADDITIONAL FRAMEWORKS FOR CONCEPTUALIZING AND ANALYZING POWER

TABLE OF CONTENTS

This document is one of three supplements that delve deeper into the concepts introduced in *Let's Talk: Redistributing power to advance health equity*.[1] *Supplement 1 – The evidence base for focusing on power imbalance as a root cause of health inequities*[2] and *Supplement 2 – Public health roles in addressing power imbalances in the Canadian context: Summary of interviews and considerations*[3] are also available for your review.

INTRODUCTION

In *Let's Talk: Redistributing power to advance health equity*,[1] we reviewed in depth one framework for conceptualizing and analyzing power — the three faces of power. Depending on the situation, other frameworks may be better suited to achieve the same purpose. In this supplementary document, we present several additional frameworks and their potential applications to public health practice.

There is no one "correct" or "best" way to conceptualize power. The value of any framework lies in its ability to help practitioners see how power is operating and to develop strategies to redistribute power to advance health equity. Practitioners in different contexts and with different perspectives may find different frameworks most useful for their work.

The frameworks included here do not include all frameworks focused on power. They were selected because there is evidence of their application to public health practice and examples of public health practitioners using them as a basis for their work.

FRAMEWORKS TO CONCEPTUALIZE AND ANALYZE POWER

EXPRESSIONS OF POWER

While power was initially equated with domination — or power over — feminist activists and scholars reframed power and introduced the concepts of power to, power with, and power within. These have been further refined to examine both individual and collective expressions of power (see Table 1).

Table 1: Expressions of power

Expression	How power operates	
As described in	Allen et al.,[4] Hunjan et al.[5] and VeneKlassen et al.[6]	Popay et al.[7]
Power over	Domination or control of one person, group or institution over another	Power over other institutions or exercise of power over a group of community members by another group
Power to	Individual ability to act	Capabilities to achieve desired ends including establishing structures, procedures and opportunities for collective decisions and actions as well as the outcomes of these
Power with	Collective action, the ability to act together	Capabilities to build alliances and act with others to achieve common goals
Power within	Individual or collective sense of self-worth, value, dignity	Capabilities internal to a community supporting collective control/action

Relevance and application to public health

Feminist scholars and activists developed conceptions of power to counter views that power is only about domination: power to, with and within. Popay et al.,[7] whose goal is advancing health equity, defined and used these expressions of power in their Emancipatory Power Framework. They focused their work on what communities can do to build power — "capabilities developed within and by communities to exercise greater collective control."[p1257] They went on to explain how the framework "illuminates the capabilities/forms of power communities have and those they need to develop."[p1258]

The authors also proposed metrics to measure these forms of power[8] and provided an evaluation of the Big Local community power-building initiative in the United Kingdom that uses the framework and metrics.[9] They concluded that, "The findings highlight the importance of designing community initiatives that: nurture diverse participatory spaces; attend to connectivity between spaces; and identify and act on existing power dynamics undermining capabilities for collective control in disadvantaged communities."[9][p1264]

Examples of questions for analyzing an issue using this framework of power

- **Power over:** Which individuals or institutions currently are exerting control over communities forced into marginalization and decisions that affect those communities? How is that control manifested? How can it be undermined?
- **Power to:** What capacities does public health need to bring together or build with communities living in marginalized conditions to be able to influence decisions?
- **Power with:** With whom can public health build alliances to support the ability of communities living in marginalized conditions to influence decisions? How can public health use its convening capacity and perceived objectivity to build those alliances?
- **Power within:** What capacities do communities forced into marginalization already have? How can public health support them developing their leadership and additional capacities that would build their power?

SOURCES OF POWER

As part of an analysis of how power is operating, it is important to consider the sources of power working to maintain the status quo and which sources of power could be harnessed to make change. Community organizers often think of building people or community power to offset the economic power of those resisting change. Several authors have identified potential sources of power (see Table 2).

Table 2: Sources of power

Source	Examples
Physical	Militaries, militia, mercenaries, peacekeeping forces, police[10]
Financial or Economic	Accessibility to financial resources (e.g., money, assets and property) and using that power to influence decision-making[11] Wealthy governments, firms, foundations, individuals[10]
Technical expertise or Knowledge and evidence or Expertise	Knowledge, skills and information held by individuals, and the individuals' authoritative claim to that knowledge[11] "Science to specification" (i.e., scientific work to support corporate or industry objectives), funding education and manufacturing doubt[12] Academics, scientists, lawyers[10]
Network and access or Relationships	Collective knowledge, action, homophily and social spaces, any well-networked individual or group of individuals[10,11] Corporate lobbying, revolving doors (i.e., former public officials becoming lobbyists and vice versa) and political donations[12]
Political or Structural	Political authority — legitimate, traditional or charismatic[11] Governments, traditional leaders[10]
Institutional or Institutional structures	Depends on institution: often governments, increasingly also firms and non-governmental organizations[10] Corporate participation in government agencies, committees and commissions, and in policy development[12]
Discursive	Media, politicians, activists, public intellectuals[10]
Ideology	The neoliberal political "project"[12]
Moral or Values	Religious leaders, social movement leaders, moral authorities[9] Individual freedom and choice[12]
Norms	Prioritization of economic over health imperatives in political decision-making[12]
Capital	Social — the actual or potential resources one gains from membership in a group. Cultural — the skills, educational qualifications, etc. acquired through membership in a group. Economic — money, property and other assets. Also through "habitus" — the socialization of actors to their social disposition[11]
Rules	Trade agreements and investment treaties[11]
Bureaucratic	Knowledge and authority of bureaucracies and the administrative machinery through which formal policies are often designed, implemented and coordinated[11]
Personal attributes	Charismatic authority as emerging from perceived exceptional powers or qualities; such attributes are tightly wound up with other individual factors such as gender, race, sexuality and religion[11]
Perceptions and preferences	Issue framing and narratives communicated through corporate foundations, front groups, think tanks and public relations companies, opinion leaders, media capture, and marketing and advertising[12]

Relevance and application to public health

Milsom et al.[12] developed their list of sources of power in their analysis of international trade regimes that impact the ability to advance policies that address non-communicable diseases, and as a complementary dimension to other frameworks of power. One of their key messages is: "Recognizing power in all its forms across different political spaces and levels is essential for enabling public health actors to identify and evaluate effective strategies for improving trade and health policy coherence."[p494] This could be broadened to include the identification and evaluation of strategies to address health inequities broadly. Their analysis of international trade explores eight sources of power (ideologies, values, knowledge and evidence, perception and preference-shaping, organizational structures, relationships, rules, norms) — along with the three faces of power described in the related Let's Talk[1] and the levels and spaces frameworks described below.

Examples of questions for analyzing an issue using this framework of power

- Which sources of power are having the greatest influence on the issue of focus or the changes we seek?
- Who or which institutions and systems are wielding that influence?
- What strategies can public health use to influence those sources of power and/or increase the influence of countervailing sources of power?

TAXONOMY OF POWER

Barnett and Duvall,[13] working in the field of international relations, also observed that the conception of power as being only about control and domination — what they called compulsory power — was limiting. They introduced and defined additional dimensions — institutional, structural, and productive power. Popay et al.[7] expanded on these ideas and applied them in a health equity context (see Table 3).

Table 3: Taxonomy of power

Concept	How power operates	
As described in	Barnett et al.[13]	Popay et al.[7]
Compulsory	The direct control of one actor over the conditions of existence and/or the actions of another	Direct and visible — exercised, for example, by formal instruments of the "state" (such as army, police, government departments) and legislation
Institutional	Actors' indirect control over the conditions of action of socially distant other	Less visible — exercised through organizational rules, procedures and norms, controlling information put into the public sphere, who is involved in decision-making, etc.
Structural	The co-constitutive, internal relations of structural positions	Invisible — works through systematic biases embedded in social institutions, generating and sustaining social hierarchies of class, gender, ethnicity, etc., in the distribution of resources, opportunities and social status
Productive	Working through "diffuse constitutive relations to produce the situated social capacities of actors"[p48] including discursive power or ideological power	Invisible — operates through diffuse social discourses and practices to legitimate some forms of knowledge while marginalizing others; shapes the meanings of different social identities

Relevance and application to public health

Alongside the Emancipatory Power Framework described above, Popay et al. also defined the Limiting Power Framework (the right-hand column in Table 3), which "identifies four forms of power that can restrict the collective control disadvantaged communities of interest/place can exercise over their own or others' decisions and actions."[7(p1258)] They noted that, "Analyses of limiting power operating in community settings reveal the intersecting social structures of class, gender, race and sexuality, etc. that create and sustain inequities within and across communities."[(p1258)] As with the Emancipatory Power Framework, the authors proposed metrics to measure these forms of power[8] and provided an evaluation of the Big Local community power-building initiative in the United Kingdom that used those metrics.[9]

Popay et al.[7] also described the following forms of resistance, which public health can support:

- **Resistance to compulsory power:** "Changes in the 'who, how and what' of policy processes locally, regionally, nationally and internationally to make them more democratic and accountable."[(p1259)]
- **Resistance to institutional power:** "Establishing/supporting new forms of leadership to influence the way political agendas are shaped and increase the visibility and legitimacy of the issues, voice and demands of disadvantaged communities/people; action for extension and protection of right to information and voice; claiming and protecting participatory spaces for community uses."[(p1259)]
- **Resistance to structural power:** "Strengthening organizations and movements of disadvantaged people locally, regionally, nationally and internationally to build their collective power through social movements of resistance/opposition and movements for positive social change; these social movements can in turn effectively resist other forms of limiting power."[(p1259)]
- **Resistance to productive power:** "Actions targeting social and political culture and individual and collective understandings to transform the way people perceive themselves and those around them, their sense of individual and collective self-worth and how they envisage the future possibilities and alternatives. Challenging dominant stigmatizing discourses about and representations of people and places through innovative use of social and other media, opportunities to develop positive collective narratives about people's histories and future possibilities to develop 'narrative resilience.'"[(p1259)]

Note that, while this conceptualization of power is different from the three faces of power described in *Let's Talk: Redistributing power to advance health equity*,[1] the actions of resistance proposed overlap extensively with the actions described in the application of the three faces framework.

Examples of questions for analyzing an issue using this framework of power

- **Compulsory power:** Who is wielding compulsory power and how? How can public health work with communities living in marginalized conditions to change the "who, how and what" of policy processes locally, regionally, nationally and internationally to make them more democratic and accountable?
- **Institutional power:** How can public health develop and support new forms of leadership to influence the way political agendas are shaped and increase the visibility and legitimacy of the issues, voice and demands of communities/people experiencing disadvantage?
- **Structural power:** How can public health strengthen organizations and movements of people experiencing disadvantage locally, regionally, nationally and internationally to build their collective power through social movements of resistance/opposition and movements for positive social change?
- **Productive power:** What dominant narratives are impacting this decision, making a particular viewpoint seem like common sense? What is a transformative narrative that we can disseminate through our communications, campaigns, programs, etc. that will make our viewpoint eventually seem like common sense? What role can public health play in developing and disseminating transformative narratives?

LEVELS AT WHICH POWER OPERATES

Several authors have proposed frameworks to describe another facet of power, the level at which it operates (see Table 4). While the Institute for Developmental Studies considered power at the local, national, and global levels,[14] Coffman et al. broke it down into individual, organizational, ecosystem, and geographic levels.[15]

Table 4: Levels at which power operates

As described in: University of Sussex, Institute of Development Studies[14]	As described in: Coffman et al.[15]
Local	**Individual**
National	**Organizational**
Global	**Ecosystem (alliances, coalitions)**
	Geographic

Relevance and application to public health

Milsom et al.[12] applied the levels of power from the Institute of Development Studies' Power Cube framework[14] in their analysis of the impact of international trade regimes. Public health practitioners could evaluate the decision-making level relevant to the health inequity on which they are focused vis-à-vis their jurisdiction and the levels at which they are likely to be able to make an impact (e.g., a local health agency is unlikely to be able to impact global trade regimes directly). This analysis should inform the actions they take.

Examples of questions for analyzing an issue using this framework of power

- Does the level (local, national, global) at which decisions of interest are being made match the level at which public health has influence? If not, what relevant decisions are being made at the level at which public health has influence and/or with whom can public health work to have influence at the appropriate level? What strategies will grow public health's influence at the level of interest?
- At which level (individual, organizational, ecosystem, geographic) is public health trying to build power? What public health programs and activities are intentionally focused on building power at each of these levels?
- What aspects of power can or should public health be mobilizing at each level?

SPACES IN WHICH POWER OPERATES

As part of what they called a Power Cube, the Institute for Developmental Studies considered power along three dimensions: 1) Lukes' three faces of power (described in *Let's Talk: Redistributing power to advance health equity* [1]); 2) the levels at which power operates (described above); and the spaces in which it operates (see Table 5).[14]

Table 5: Spaces in which power operates[14]

Space	Access to this space
Closed	Participation is not part of the decision-making process; decisions are made behind closed doors (e.g., trade, macroeconomic and finance policies, military policies)
Invited	Participation is invited by authorities, be they government, supranational agencies or non-governmental organizations
Claimed/created	Participation forums created by relatively powerless or excluded groups, including those created by social movements and community associations and those involving natural places where people gather to debate, discuss and resist, outside of the institutionalized policy arenas

Relevance and application to public health

Milsom et al.[12] also applied the spaces of power from the Institute of Development Studies' Power Cube framework[14] in their analysis of the impact of international trade regimes. International trade negotiations are closed spaces that exclude community members living in marginalized conditions. Public health practitioners may be invited into these spaces but typically not on equal terms (e.g., they are typically far outnumbered by industry representatives). An understanding of the decision-making space is critical for identifying strategic actions public health practitioners can take and support.

Examples of questions for analyzing an issue using this framework of power

- In which of these spaces are relevant decisions being made? Do communities forced into marginalization have access to the space? If not, does public health have access, and can it use that access to (a) influence the decision and/or (b) bring in members of communities who have been marginalized?
- What strategies can public health use to open up the space further? Should public health help create an alternative space and use it to influence decisions?

ARENAS IN WHICH POWER OPERATES

Pastor et al. proposed that power must be contested in multiple arenas (see Table 6), in addition to multiple geographic scales and on multiple issues.[16]. They contended that a focus on only one of these arenas (e.g., electoral) was insufficient, as advances made in that arena must be secured through advances in other arenas.

Table 6: Arenas in which power operates[16]

Arena	Decision-making or influence in this arena
Electoral	Voters are the decision-makers, shaping policy indirectly through electing representatives or directly through ballot initiatives
Legislative	Elected officials and policy-makers are the decision-makers as they propose, craft and approve (or disapprove) laws
Judicial	Courts and judges are the decision-makers as they determine the legality of policies and practices
Administrative	Executive officials and government staff are the decision-makers as they oversee and implement laws and rules, coordinate agencies and regulatory bodies, and administer public participation processes
Corporate	Business management and corporate vested interests make decisions that directly affect workers and families
Communications	The power to influence the values, world views and understandings of the public at large

Relevance and application to public health

Governmental public health operates within the administrative arena of power. It therefore has decision-making authority in many areas and can use that to advance health equity. Through a Health in All Policies approach, public health can influence others in the administrative arena (e.g., a housing agency). Public health may also be able to develop strategies to influence other arenas of power (e.g., issuing reports that impact, and testifying in, the legislative arena; filing court briefs in the judicial arena).

Examples of questions for analyzing an issue using this framework of power

- In administrative arenas, how can public health use its influence to advance equity, including through the use of Health in All Policies?
- For decisions being made in non-administrative arenas, what strategies can public health employ, in coordination and/or partnership with communities forced into marginalization, to change power imbalances and advance equity? For example, can public health run programs that encourage voting (electoral space) or lead narrative change work (communications space)? What face of power can or should public health be mobilizing in each arena?

CAPACITIES NEEDED TO BUILD POWER

Table 7 summarizes some helpful sets of capacities necessary to build power from leading researchers. The sets overlap significantly and yet also contain unique elements.

Table 7: Capacities needed to build power

As described in: Pastor et al.[16]	As described in: Coffman et al.[15]	As described in: Pastor et al.[17]
Organizational breadth and depth **Networks and alliances** **Leadership ladders and lattices** **Resource bases**	**Organizing** **Civic engagement and electoral** **Narrative** **Advocacy** **Governing** **Developmental and supportive** **Adaptive**	**Organizing and base building (including civic engagement and electoral work)** **Advocacy and policy** **Research and legal** **Communications and cultural and narrative change** **Alliances and coalitions** **Leadership development** **Organizational development, infrastructure and funders**

Relevance and application to public health

Pastor et al.[17] described capacities needed for building community power to advance health equity. Central to their list is organizing and base building, while the other capacities support that organizing (see Figure 1).

Figure 1: Power-building capacities[17(p11)]

Public health can support communities developing each of these capacities, the implementation of strategies that employ these capacities, and the formation and collaboration of coalitions that bring together actors that provide these capacities.

Examples of questions for analyzing an issue using this framework of power

- With which community-organizing groups can public health partner? Which capacities does the community experiencing marginalization already have? How can public health support the development of missing capacities and/or coalition building that brings missing capacities? (See also questions above, in the section on expressions of power, for power to, power with and power within.)

ACTORS

The literature on power contains descriptions and examples of many different actors who may hold power. These are coalesced into Table 8. Some of these are people or groups who hold particular positions (e.g., judges), while others are descriptions of roles people or groups may hold (e.g., researchers).

Table 8: Actors

Who may have power to change structures?
Elected leaders
Government offices and employees
Courts and judges
Military and police
Corporations and corporate leaders
Those who control capital (financial, natural resources)
Media (including social media corporations)
Lawyers
Advocacy groups
Cultural leaders (including religious leaders, media stars, charismatic leaders)
Researchers and those who control information (academics, think tanks)
Consumers
Workers and unions
Community members, leaders and organizations (including Indigenous groups)

Relevance and application to public health

Public health practitioners may play some of these roles (e.g., government offices, researchers) and can work to influence decisions from those positions. They can also identify the other actors relevant to a decision-making process and use power analysis tools (see next section) to strategically identify whom to attempt to influence in decisions that affect health equity.

Examples of questions for analyzing an issue using this framework of power

- Which of these actors are active on the issue of interest? Can public health influence their positions and activities?
- Which of these actors are not yet active on the issue of interest? Can public health use its relationships to engage additional actors aligned with advancing equity?

POWER ANALYSIS TOOLS AND STRATEGIES

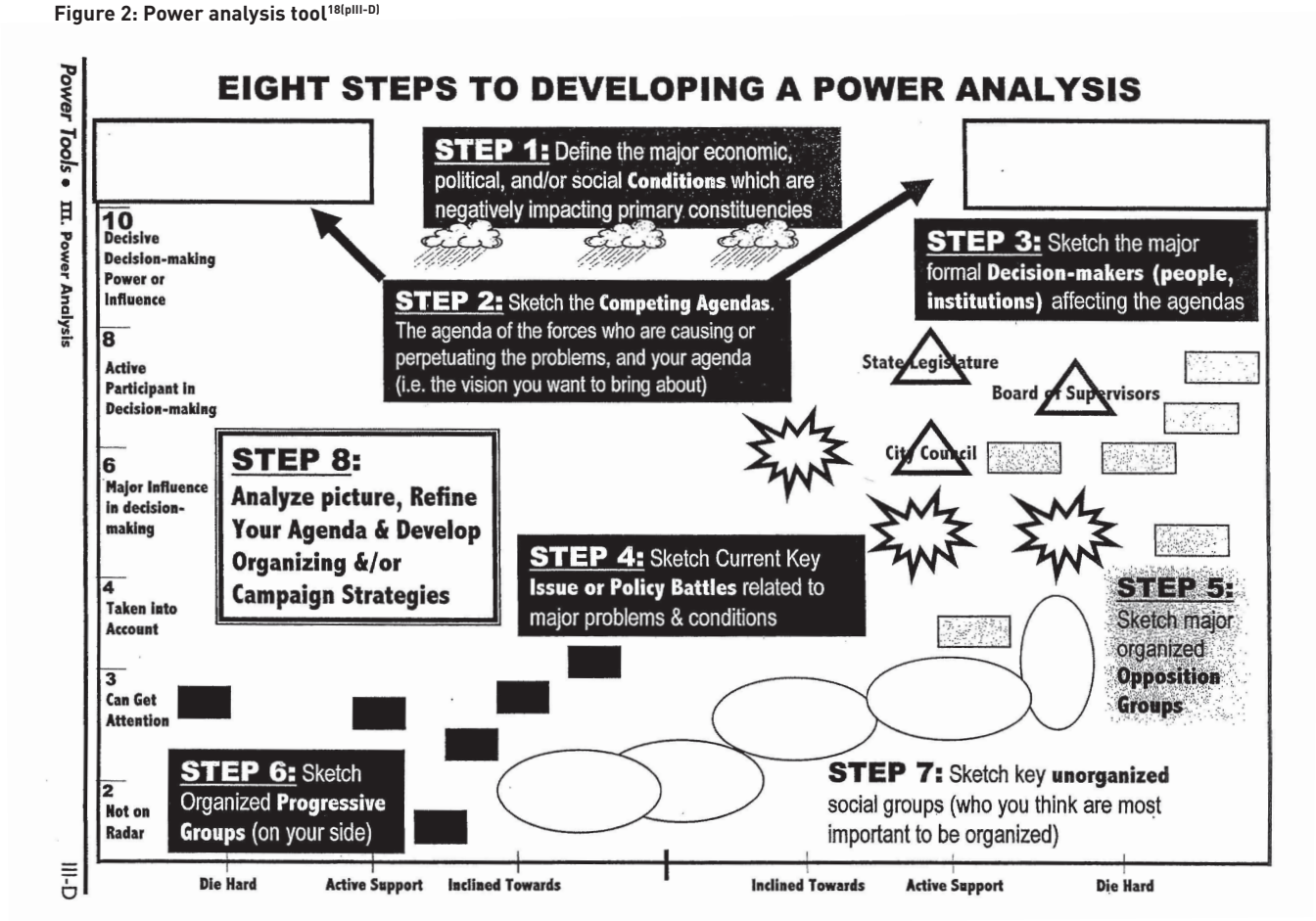
The frameworks described so far can be used in specific policy, systems and structural change initiatives to understand the power dynamics at play and to devise strategies both to build power with those interested in advancing health equity and to limit the power of those interested in maintaining the status quo or advancing changes that lead to health inequity. Below we describe tools that have been developed to support such analysis.

POWER TOOLS

In 2003, Strategic Concepts in Organizing and Policy Education (SCOPE), a community organizing group in Los Angeles, released *Power tools*, a guide to doing a power analysis (including a chapter with exercises and templates).[18] A number of steps are described, but the main idea is to place all those involved in a decision-making process on a two-dimensional graph, where the horizontal axis describes whether the group is for or against an equity agenda and the vertical axis describes how much power they have. Figure 2 shows an image of this graph with the steps they described.

This kind of mapping exercise enables a coalition to develop a shared analysis of an issue and to recognize who they should focus on influencing or supporting, and where the biggest obstacles to their work may come from. This strategy may enable various groups to come together in an organized manner to promote a policy or change they are interested in.

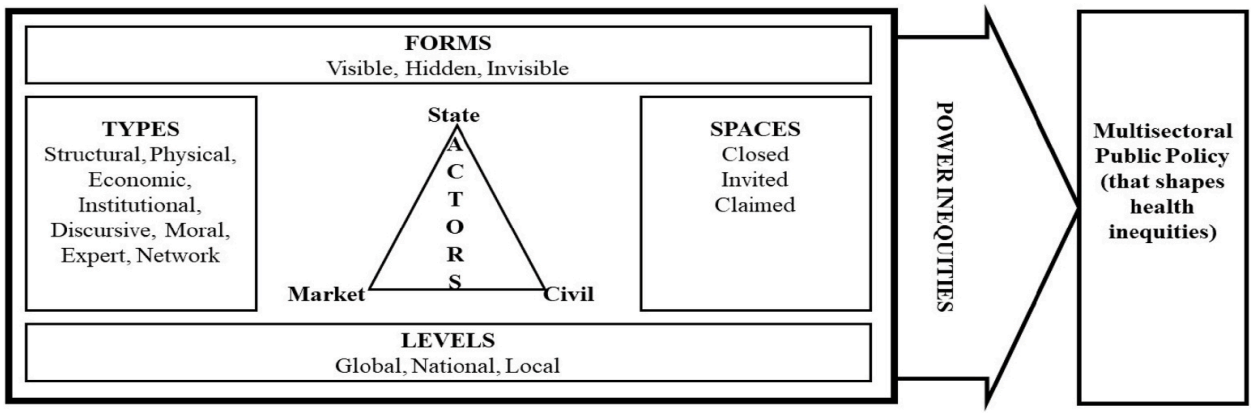
Figure 2: Power analysis tool[18(pIII-D)]



HEALTH EQUITY POWER FRAMEWORK

Friel et al. developed and applied retrospectively a power analysis tool they named the Health Equity Power Framework[19] (Figure 3). We share their tool, a long excerpt from their findings, and their strategies as an example of what working in this way can yield.

Figure 3: Health Equity Power Framework[19(p4)]



Through interviews, Friel et al. analyzed seven Australian policy debates related to the determinants of health: Trans Pacific Partnership (TPP) agreement, Paid Parental Leave (PPL), National Broadband Network (NBN), Western Sydney City Deal (WSCD), Northern Territory Emergency Response (NTER), Closing the Gap (CTG) health policies, and Primary Health Care policy. Their key findings are:

> Our analysis exposes the power dynamics underlying these issues. We see how structural power permeates public policy processes in multiple ways. The socially created rules and mandates, especially associated with neoliberalism, racism, sexism and biomedicalism, guide and constrain policy decision-makers' choices, through setting the expectations about how the game should be played and who has power in the game. As we saw with the TPP, NBN, WSCD, and NTER this helps to reinforce social and political values, and institutional practices within government. In doing so, government becomes a contested space within which different actors compete and cooperate to influence policy. What we saw in our data was the structurally powerful groups working in that space to advance their interests, keeping topics that threaten their interests off the agenda, and thus maintaining existing power asymmetries and policy foci. The result in these cases was an unquestioning acceptance of market-primacy, and state-supremacy that resulted in trade, planning, and infrastructure policies that undermined the conditions necessary for health equity, and in the case of the NTER, a flagrant abuse of human rights through the implementation of a racially driven policy.
>
> We also found that forms of invisible structural power, enabled by expert power, were used to limit normative social views of "health" to individualized biomedical or behavioural conceptions. Thus "health" became conceptually equivalent to use or availability of biomedical interventions to avoid illness, or exercise of individual choices, and behaviours to maintain healthy behaviours. An important effect of this is the constraining of responsibility and leadership for health equity to the health sector, thus embedding an institutional path dependency that is difficult to rectify. In addition, adoption of the biomedical view of health as the norm serves to maintain the economic power of those who deliver the therapies, medications or behavioural programs that ostensibly cultivate "health". In this context, the aim of health equity can be readily "converted" within policy implementation to strategies focused on "vulnerable" populations rather than addressing the conditions that create health risk among populations.
>
> Institutionally, the analysis reveals biased processes that constrain public-interest actors' ability to bring social and health equity issues into policy debates. However, the analysis also revealed the ways in which different actors navigate and change these processes to achieve their goals. For structurally weaker actors, getting into the mainstream institutional policy

processes, "having a voice at the table", was a challenge. A second challenge was the recalibration of institutional path dependencies. Making use of different spaces and venues, and drawing on their network and moral powers, enabled these actors and coalitions of actors to achieve some success in the cases of PPL and CTG. Notably, the use of expertise and/or evidence was punctuated variably throughout the policy cases, with it being invited into the policy process when there was institutional desire for it and the expert evidence supported the political argument – as we saw, for example, in the case of the NBN.

Discursive power, in the form of hegemony, narratives and moral authority, played a major role across the cases. The different uses of discursive power served to both amplify and diminish inequities in structural and institutional forms of power. The combination of discursive/moral/expert power was exercised most successfully by public interest actors in the agenda setting phase. At the implementation phase, structural power and institutional processes seemed to be able to dominate and prevent social and health equity actors elevating their interests through discourse.[19(p10)]

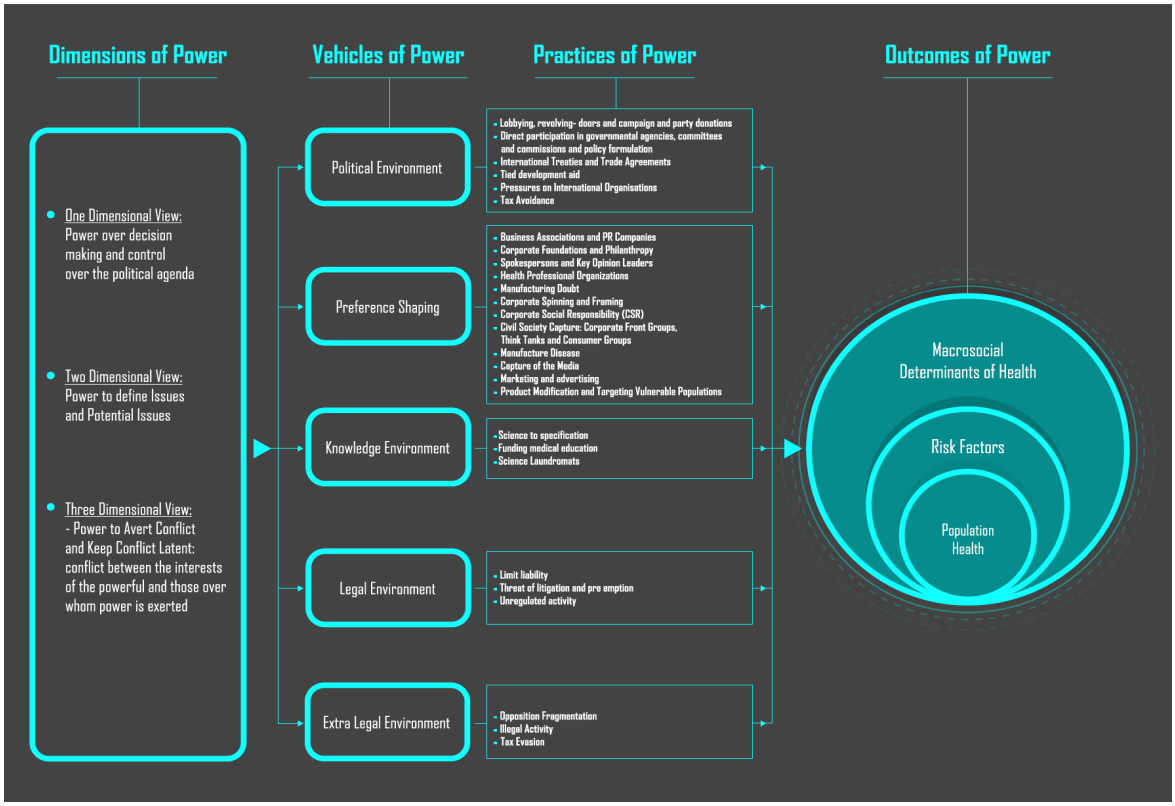
This analysis revealed to the authors four strategies for advancing health equity: change the narrative, use claimed spaces to build coalitions, "get inside" closed or invited spaces in order to drive institutional change, and make hidden processes more visible to public scrutiny.[19]

CORPORATE PRACTICES AND HEALTH

Madureira Lima and Galea[20] developed "a framework to systematically study corporations and other commercial interests as a distal, structural, societal factor that causes disease and injury."[p1] Their framework "offers a systematic approach to mapping corporate activity, allowing us to anticipate and prevent actions that may have a deleterious effect on population health."[p1]

Their framework is based on the three faces of power framework described in *Let's Talk: Redistributing power to advance health equity*[1] and shown in Figure 4. In their paper, Madureira Lima and Galea described and provided health-related examples of each of the "vehicles of power" and "practices of power."

Figure 4: Dimensions, vehicles, practices and outcomes of power[20(p2)]



They concluded:

> Corporate activities have immediate and observable effects on perceptions and behaviour patterns that can lead to increased consumption of unhealthful corporate products and subsequently to changes to individual and population health.... Our framework offers a systematic way of mapping corporate action as a way of guiding research and practice. It is meant to be used by public health practitioners, researchers, students, activists and other members of civil society, policy makers and public servants in charge of policy implementation. It can also be useful to corporate managers who wish to establish or improve triple bottom line [people, planet and prosperity] principles.[20(p9)]

CONCLUSION

The frameworks and power analysis tools described in *Let's Talk: Redistributing power to advance health equity*[1] and in this supplement — many of which have already been applied in public health settings — can be used alone or in combination to identify how power is manifest in the issues we care about. Understanding this is crucial to making structural changes, and only when we understand how power is operating can we develop strategies and take actions to redistribute power, a key component of advancing health equity.

REFERENCES

1. National Collaborating Centre for Determinants of Health. Let's talk: redistributing power to advance health equity [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2023 Jul 10]. 19 p. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets_Talk_Redistributing_Power_to_Advance_Health_Equity_EN.pdf
2. National Collaborating Centre for Determinants of Health. Let's talk: redistributing power to advance health equity. Supplement 1 – The evidence base for focusing on power imbalance as a root cause of health inequities [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2023 Sept 6]. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets-talk-power-Supplement-1_EN.pdf
3. National Collaborating Centre for Determinants of Health. Let's talk: redistributing power to advance health equity. Supplement 2 – Public health roles in addressing power imbalances in the Canadian context: summary of interviews and considerations [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2023 Sept 6]. Available from: https://nccdh.ca/images/uploads/NCCDH_Lets-talk-power-Supplement-2_EN.pdf
4. Allen A. Rethinking power. Hypatia. 1998 Feb;13(1):21–40. doi: 10.1111/j.1527-2001.1998.tb01350.x.
5. Hunjan R, Keophilavong S. Power and making change happen [Internet]. Dunfermline (UK): Carnegie UK Trust; 2010 Nov [cited 2023 Jul 10]. 33 p. Available from: https://carnegieuktrust.org.uk/publications/power-and-making-change-happen/
6. VeneKlasen L, Miller V. A new weave of power, people & politics: the action guide for advocacy and citizen participation [Internet]. Washington (DC): Just Associates; 2007 Aug 4 [cited 2023 Jul 10]. 336 p. Available from: https://justassociates.org/all-resources/a-new-weave-of-power-people-politics-the-action-guide-for-advocacy-and-citizen-participation/.
7. Popay J, Whitehead M, Ponsford R, Egan M, Mead R. Power, control, communities and health inequalities I: theories, concepts and analytical frameworks. Health Promot Int. 2021 Oct;36(5):1253–63. doi: 10.1093/heapro/daaa133.
8. Ponsford R, Collins M, Egan M, Halliday E, Lewis S, Orton L, et al. Power, control, communities and health inequalities. Part II: measuring shifts in power. Health Promot Int. 2021 Oct;36(5):1290–9. doi: 10.1093/heapro/daaa019.
9. Powell K, Barnes A, Anderson de Cuevas R, Bambra C, Halliday E, Lewis S, et al. Power, control, communities and health inequalities III: participatory spaces—an English case. Health Promot Int. 2021 Oct;36(5):1264–74. doi: 10.1093/heapro/daaa059.
10. Moon S. Power in global governance: an expanded typology from global health. Global Health. 2019;15(Suppl 1):Article 74 [9 p.]. doi: 10.1186/s12992-019-0515-5.
11. Sriram V, Topp SM, Schaaf M, Mishra A, Flores W, Rajasulochana SR, et al. 10 best resources on power in health policy and systems in low- and middle-income countries. Health Policy Plan. 2018 May;33(4):611–21. doi: 10.1093/heapol/czy008.
12. Milsom P, Smith R, Baker P, Walls H. Corporate power and the international trade regime preventing progressive policy action on non-communicable diseases: a realist review. Health Policy Plan. 2021 May;36(4):493–508. doi: 10.1093/heapol/czaa148.
13. Barnett M, Duvall R. Power in international politics. Int Organ. 2005 Winter;59(1):39–75. doi: 10.1017/S0020818305050010.
14. University of Sussex, Institute of Development Studies. Power pack: understanding power for social change [Internet]. Brighton (UK): IDS; 2011 [cited 2023 Jul 10]. 90 p. Available from: https://www.powercube.net/wp-content/uploads/2011/04/powerpack-web-version-2011.pdf
15. Coffman J, Barsoum G, Lopez A, Brothe Gantz M. Advocacy that builds power: transforming policies and systems for health and racial equity [Internet]. Washington (DC): Center for Evaluation Innovation; 2021 Mar [cited 2023 Jul 10]. 54 p. Available from: https://www.evaluationinnovation.org/wp-content/uploads/2021/04/Advocacy-that-Builds-Power.pdf
16. Pastor M, Ito J, Wander M. Changing states: a framework for progressive governance [Internet]. Los Angeles (CA): University of Southern California, Program for Environmental and Regional Equity; 2016 May [cited 2023 Jul 10]. 72 p. Available from: https://dornsife.usc.edu/eri/wp-content/uploads/sites/41/2023/01/2016ChangingStatesPERE.pdf
17. Pastor M, Ito J, Wander M, Thomas AK, Moreno C, Gonzalez D, et al. A primer on community power, place, and structural change [Internet]. Los Angeles (CA): University of Southern California, Equity Research Institute; 2020 Sep [cited 2023 Jul 10]. 26 p. Available from: https://dornsife.usc.edu/assets/sites/1411/docs/Primer_on_Structural_Change_web_lead_local.pdf
18. Pateriya D, Castellanos P. Power tools: a manual for organizations fighting for justice [Internet]. Los Angeles (CA): Strategic Concepts in Organizing and Policy Education (SCOPE); 2003. Chapter III, Power analysis; [cited 2023 Jul 10]; p. III-1–BB. Available from: https://calbudgetcenter.org/wp-content/uploads/SCOPE-Power-Analysis-Chapter.pdf
19. Friel S, Townsend B, Fisher M, Harris P, Freeman T, Baum F. Power and the people's health. Soc Sci Med. 2021 Aug;282:Article 114173 [12 p.]. doi: 10.1016/j.socscimed.2021.114173.
20. Madureira Lima J, Galea S. Corporate practices and health: a framework and mechanisms. Global Health. 2018;14:Article 21 [12 p.]. doi: 10.1186/s12992-018-0336-y.

National Collaborating Centre for Determinants of Health
Centre de collaboration nationale des déterminants de la santé

NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH
St. Francis Xavier University
Antigonish, NS B2G 2W5
(902) 867-6133
nccdh@stfx.ca
www.nccdh.ca
Twitter: @NCCDH_CCNDS

ACKNOWLEDGEMENTS

This *Let's Talk* supplement was written by Jonathan Heller, Visiting Scholar, and Myrianne Richard, Knowledge Translation Specialist, at the National Collaborating Centre for Determinants of Health (NCCDH). Internal review was provided by Claire Betker, Scientific Director, NCCDH.

The NCCDH is hosted by St. Francis Xavier University. We are located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq people.

Please cite information contained in the document as follows: National Collaborating Centre for Determinants of Health. (2023). *Let's Talk: Redistributing power to advance health equity. Supplement 3 – Additional frameworks for conceptualizing and analyzing power.* Antigonish, NS: NCCDH, St. Francis Xavier University.

ISBN: 978-1-998022-26-7

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the NCCDH. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada. This document is available on the NCCDH website at www.nccdh.ca.

La version française est également disponible au www.ccnds.ca sous le titre *Repenser la répartition du pouvoir pour favoriser l'équité en santé : Parlons-en. Supplément 3 – Les autres cadres utiles à la conceptualisation et à l'analyse du pouvoir.*