Case Study 8

Community Empowerment

KATHLEEN M. MAY
SANDRA L. FERKETICH

BACKGROUND

In response to a request for applications (RFA) from the Agency for Health Care Policy and Research, the National Institute of Nursing Research, and the Division of Nursing, College of Nursing faculty members at the University of Arizona (UA researchers) and Pinal County Department of Public Health (PCDPH) staff collaborated to design a project testing three components of a community health nursing model in rural communities (Ferketich, Phillips, & Verran, 1990).

PROJECT PLANNING

The plan for the project began with assessment of population health data and community interest by a team of UA researchers. An extensive analysis of population health data for rural communities and surrounding areas in the state of Arizona revealed that five small, rural, underserved communities in one county met the criteria for study inclusion as published in the RFA from the sponsoring groups. The UA researchers contacted PCDPH staff in the county and collaborated for further assessment and planning. Two of the communities had populations of under 1,000 people and were adjacent communities, so these had to be considered as one community, resulting in a total of four communities identified as target communities for the project. The PCDPH had a departmental structure and mission based on a traditional community health nursing model, which included public health nurses’ role in providing generalist nursing services, including outreach, case finding, and case management. This was important in that differences in health care delivery systems needed to be controlled for the experimental design of the project.

The selected communities were both underserved and interested in assistance. Because the RFA had a deadline of 1 month, complete community involvement in preparation for the response to the RFA was not possible at that stage. Meetings of the UA researchers with PCDPH staff provided input on current services available to the communities.

The project was planned for the four communities, each of which met criteria for rural areas (U.S. Congress, Office of Technology Assessment, 1990). Each of the four communities had fewer than 2,500 residents and was not included in any standard metropolitan statistical area (SMSA). Each community was at least 40 to 75 miles from any major urban area and was in a county with no urban area with a population of 50,000 or more (U.S. Congress, Office of Technology Assessment, 1990). All communities were medically underserved and had populations with low incomes, substandard housing,

AUTHORS’ NOTE: This case study is based on a project funded by Grant #1-R18-HSO6801-01, Agency for Health Care Policy and Research (co-principal investigators: Sandra L. Ferketich, Linda R. Phillips, and Joyce Verran).
elderly subpopulations, and high unemployment. The communities had an economic structure based on copper mining and few, if any, migrant workers.

**PROJECT DESIGN**

The project design included three interventions:

1. Personalized preventive nursing, providing clinic services and community health nurse home visits by a clinic nurse
2. Organized indigenous caregiving, providing outreach health care by community health nurses and promotoras (lay health workers promoting health)
3. Community empowerment, fostering community identification of health problems, resources, and solutions by community members, including community health nurses and promotoras

Each of the four communities received randomly assigned interventions. The focal community for this case study received both organized indigenous caregiving and community empowerment. However, this case study addresses only the community empowerment intervention, which was in effect for 18 months. Funding limitations precluded the possibility of a community empowerment intervention of longer duration.

**COMMUNITY EMPOWERMENT FRAMEWORK**

A community development approach to community organization, formerly called locality development (Rothman, 1970), provided the basis for the community empowerment intervention. Using this framework, the project emphasized involvement in problem solving by community members, including community health nurses from nearby communities and neighborhood workers (Rothman, 1970), who were called promotoras in this project.

In this framework for community empowerment, communities were supported in exerting their ownership of problems and solutions (Wallerstein, 1992) related to health. The role of health professionals in community empowerment is to listen and help community members to identify problems and strengths, develop plans, and act (Wallerstein, 1992). The community health nurses and promotoras implemented the community empowerment intervention by planning strategies to foster community participation and control. In this effort, the UA researchers and PCDPH staff provided consultation and support for the community health nurse and promotoras. A description of the community provides background for outlining the intervention.

**DESCRIPTION OF THE COMMUNITY**

The community is a small town located in a river valley divided by a highway and some hills along the river. Much of the community lives in old housing, with 13% of residents living in trailers. There is an elementary school, a town hall, a small courthouse and municipal building, a small building used for community services, and small stores, mostly located along the highway.

In the community of 532 households, 66% are Mexican American. Most residents are long-term members of the community and have close ties to extended family members. For many years, mining was a primary source of income for community members, but the economy had suffered ill effects in recent years due to decreasing employment opportunities in the mines. Some residents believed the environmental effects of mining on the town included pollution of groundwater and contamination due to residue from mining wastes dropped from trucks traveling through town several times a day. Before the project, the only health services in the town were provided once a week, at the small building for community services, used by the PCDPH for a clinic staffed by community health nurses. During the project, clinic was held in the same building once a week, and the community health nurse and promotoras used the offices each day to implement the project interventions, including the community empowerment intervention.

**THE INTERVENTION**

The focus of this case study is the planning, implementation, and evaluation of a community empowerment intervention in one community.
The major goal of the community empowerment intervention was the "redistribution of decision making power" (Ferketich et al., 1990, p. 46). This goal was further specified to be measured in five outcomes: (a) increased cultural sensitivity of organized health care programs, (b) redistribution of health resources, (c) refocusing of existing health programs on health needs identified by the community itself, (d) the creation of new health services and programs that are desired by the community, and (e) increased acceptability and accessibility of the services available (Ferketich et al., 1990, p. 51).

To achieve the desired overall goal and outcomes, strategies were (a) identifying resources in the community, (b) eliciting community support, (c) mobilizing resources for assessment, (d) mobilizing resources for creating interventions, and (e) training community members to continue after the project ended (Ferketich et al., 1990, p. 50).

\[ \text{ROLE OF COMMUNITY HEALTH NURSE AND PROMOTORAS} \]

To implement the community empowerment intervention, a community health nurse and two promotoras, Mexican American community residents who were high school graduates, were hired. The community health nurse was a Mexican American baccalaureate-prepared RN from a nearby rural community, hired to spend half time on indigenous caregiving (outreach activities aimed at neighbors to improve access to health care) and half on community empowerment. The promotoras were hired part time for a total of .50 FTE.

UA researchers met with the community health nurse and promotoras for an orientation program, with sessions held at least once a week for the 6 weeks, to give an overview of community empowerment and explore how to apply the philosophy of the project. Researchers explained the role of the health professional in the project and how it reflected a philosophy of community empowerment. Sessions included informal verbal presentations by UA researchers, printed materials, discussion, and presentations by the community health nurse and promotoras, in which they gained practice in speaking before a group.

The role of the community health nurse and the promotoras was characterized as (a) helping the community to identify, prioritize, and solve problems; (b) encouraging community self-help; (c) advocating community participation in health-related decisions; (d) applying the community's knowledge of the local situation, resources, and networks to develop health programs; and (e) giving support as team members rather than as organizers. The community health nurse was the immediate supervisor of the promotoras and guided them in planning and implementing strategies for building partnerships with individuals and groups.

\[ \text{IMPLEMENTATION} \]

Implementation of the community empowerment intervention began with close teamwork by the community health nurse and promotoras, with consultation from UA researchers, in identifying community resources, including people active in the community. In the process of talking with community members, describing the intervention, and the ultimate purpose of enhancing the health of the community, they elicited community support.

Further strategies for assessment and implementation included (a) conducting a community survey to obtain baseline data and become familiar with community perceptions, (b) identifying community goals and issues requiring political action, (c) identifying individuals and groups already active in the community, and (d) implementing activities such as a health fair and a legislative hearing, through which partnership of team members with other community members fostered community empowerment.

\[ \text{COMMUNITY SURVEY} \]

With community support, the UA researchers trained survey interviewers to conduct a survey as part of a community assessment. To establish a database for evaluating community needs and strengths and for planning the community empowerment intervention, a door-to-door community survey was done. UA researchers conducted more in-depth interviews with key community informants. The community health nurse and promotoras, UA researchers, and PCDPH staff collaborated in using results of the community survey and interviews to formalize a list of identified community goals.
COMMUNITY GOALS

The community health nurse, promotoras, UA researchers, and PCDPH staff reviewed survey and key informant interview data to formulate and prioritize community data-based health goals. Eleven community goals derived from the data were worded in terms of what targeted residents would do as a result of the interventions of the project. Any of the three interventions (personalized preventive nursing, organized indigenous caregiving, and community empowerment) could address any of the goals. After establishing relationships with community members and informing them of the project, the community health nurse and promotoras planned community empowerment strategies to address the goals.

PLANNING SESSIONS

The community health nurse and promotoras met in weekly staff meetings to plan and evaluate strategies for the community empowerment intervention. Although they wholeheartedly supported the philosophy, the question was, “How do we do it?” The UA researchers, at the request of the community health nurse and promotoras, provided ongoing assistance with designing strategies to implement the philosophy. They provided this assistance in monthly meetings of the total project staff, and through bi-weekly on-site consultation. However, true to the community empowerment philosophy, the UA researchers provided consultation while emphasizing that the community, including the community health nurse and promotoras, had primary responsibility for identifying problems, resources, and solutions.

PARTNERSHIP WITH COMMUNITY

Gaining community support through the survey and key informant interviews, the project provided a basis for the community health nurse and promotoras to further identify individuals and groups already active in the community. The community health nurse and promotoras knew many who were community leaders. They made appointments to talk individually with community public officials, describe the project, and discuss community goals and issues. Community leaders expressed verbal support of the project.

By talking informally with other community members, the community health nurse and promotoras encountered people who were not in official positions but who were active in supporting community activities. Through informal contacts, they continued to hear community members’ perceptions about their health concerns and resources. Promotoras conducted informal discussion sessions in their own and other community residents’ homes to discuss issues of interest and generate strategies.

The community health nurse and promotoras made themselves visible in the community by attending community meetings, talking with community members in public places, and distributing flyers about clinic services. The clinic services were part of another intervention, but by using various avenues of communication, the community health nurse and promotoras became recognized and developed relationships that were helpful in implementing community empowerment.

The promotoras became more active in community groups, such as a coalition formed to coordinate gleaning for community members. All of these efforts increased the visibility of the community health nurse and the promotoras, who, in turn, were contacted more frequently by community members when community issues arose.

A specific example of how the community health nurse and promotoras mobilized resources for assessment, mobilized resources for creating an intervention, and trained community members to continue empowerment strategies was with a health fair, described here as the second health fair.

HEALTH FAIR

A community empowerment strategy previously described was the implementation of a community health fair (May, Mendelson, & Ferketich, 1995). In the early planning phase of the project, a committee of UA researchers, community members, and PCDPH staff had sponsored a community health fair. The UA researchers gathered brochures and health appraisal equipment and materials, and played a major role in providing basic ideas, planning, and personnel. This health fair, attended by about 60 commu-
In the support of the community health nurse and promotoras, who were not in active in supporting their health concerns, the promotoras conducted interviews with community members to discuss strategies.

Community empowerment was achieved through informal meetings and the setting up of promotoras in community centers to engage in discussions with health fair attendees. The promotoras, with minimal facilitation by UA researchers, assumed major responsibility for planning, implementing, and evaluating the health fair. The promotoras assessed community members' perceptions of types of information and activities that would be desirable at the health fair. They marketed the health fair to the community and elicited support from neighbors, friends, and families, resulting in the attendance of 300 residents. Community members participated in making the health fair happen and learned what went into implementing such an activity. This community empowerment intervention was evaluated as much more successful than the strategy used for the first health fair (May et al., 1995), demonstrating the effect of community ownership of planning and implementing a project.

OTHER EMPOWERMENT STRATEGIES

The community health nurse and promotoras became involved in many other activities directed toward community empowerment. On an issue of importance to the community, they initiated letter writing to legislators to support continuation of, and increases in, services to the community. They became active in community organizations dealing with community issues, such as a coalition for clean energy initiatives. They built partnerships with organizations that have interest in community members in other towns to participate in health fairs. And they elicited support from community members to convey to legislators and community leaders, through a legislative hearing, the need for health services for the community.

LEGISLATIVE HEARING

As the research project neared the end of the funding period, townspeople became concerned about the prospect of the loss of services of the community health nurse and promotoras. With the assistance of the UA researchers, the community health nurse and promotoras set up a legislative hearing. The promotoras talked with community members about the importance of the hearing and the need for community members to participate. In consultation with the UA researchers, the promotoras set up rehearsals to help community members prepare for the hearing. Most of the townspeople had not attended a hearing, much less presented testimony at one. Many could not understand or speak English; or if English was a second language, some preferred to speak in Spanish because they felt more comfortable with their primary language. It was arranged to have a translator available, and all proceedings were conducted in English and Spanish.

As the time arrived for the hearing, only 5 or 6 people came at the scheduled time. However, within 15 to 20 minutes (the meeting was delayed to allow for additional arrivals), the room filled and reached a total of about 45 townspeople. This exceeded the room's capacity, according to fire regulations. However, the fire chief and mayor were there and decided the size of the crowd was acceptable. In addition to the community residents, there were six county, local, and state representatives present to hear the community members' testimony.

Community members presenting testimony were very nervous in this new endeavor, and several presenters were undocumented residents who were especially nervous over the chance that they were taking. However, they testified that the continued presence of the nursing personnel was essential.

One woman stated that she had brought her infant to the clinic. The infant was not breathing, appeared cyanotic, and was in acute distress. The bilingual community health nurse and promotoras quickly determined that the infant had inhaled some food. The community health nurse performed the Heimlich maneuver, and the baby recovered. This mother was adamant that if the nurse had not been there and had not spoken Spanish, her baby would have died. Others described less dramatic but equally compelling arguments for the continued presence of the community health nurse and promotoras.

EVALUATION

Evaluation of the effectiveness of the community empowerment intervention necessitated examination of achievement of the major goal, redistribution of decision-making power, and the five specific outcomes identified previously.
in this case study. The evaluation begins with the five specific outcomes identified for the community empowerment intervention: (a) cultural sensitivity, (b) redistribution of health resources, (c) refocusing of existing health programs, (d) new health services, and (e) acceptability and accessibility of services (Ferketich et al., 1990). Evaluation of accomplishment of the major goal follows evaluation of the specific outcomes.

CULTURAL SENSITIVITY

The first outcome of the intervention was to be increased cultural sensitivity of organized health care programs. The major organized health program in the community was the clinic service offered by PCDPH. For the duration of the project, the clinic services were expanded. The community health nurse and promotoras for community empowerment were bilingual in English and Spanish. They were successful in soliciting and obtaining many educational materials in Spanish, which were used in the clinic, in health education classes, and at the health fair.

Through interactions with health care professionals in nearby communities, the community health nurse and promotoras increased responsiveness to the difficulties of Mexican and Mexican American clients, as evidenced by requests for translation and assistance. The project, community health nurse, and promotoras, supported by community members, reinforced the importance of culturally sensitive county health services.

REDISTRIBUTION OF HEALTH RESOURCES

Through the community empowerment intervention, the health department and other agencies increased attention toward the community, as people became aware of the work of the community health nurse and promotoras. The community health nurse and promotoras initiated community support for, and participation in, mobile screening units, group health education sessions, and support groups (e.g., for weight loss and decrease in family violence). Gaps in services were identified, including difficulty in transportation from the community to services. There was permanent redistribution of services to the community through a new community health center, begun as an outcome of this project.

REFOCUSING OF EXISTING HEALTH PROGRAMS

The health fair booths, support groups, and other strategies reflected a focusing of existing health programs on health needs identified by the community itself. One example of community ownership of health problems and solutions was in the second health fair. The positive response of the community in its involvement in planning and attendance implies a degree of community empowerment. The existing health program of the PCDPH expressed commitment to meeting the health needs of the community, which does not necessarily reflect refocusing but does indicate continued support.

CREATION OF NEW HEALTH SERVICES

Before and during the project, many community members expressed desire for a permanent community clinic. An effect of the project was success in creating a new health service that was desired by the community, in the form of a community health center.

As the research funding was ending, the UA researchers, PCDPH, and residents used their best efforts to negotiate with a health care network with services in Tucson, through nursing administration, to set up a clinic in the rural community. An asset was the fact that the project had prepared a trained group of people in the rural community who could continue with a clinic set up by the health care network. All project staff in the community were hired as the new community health center staff, in roles as community health nurse and promotoras.

INCREASED ACCEPTABILITY AND ACCESSIBILITY

Although awareness of transportation difficulties was raised and the topic was the focus of town meetings between project staff and community members, there was no permanent change in accessibility through transportation as a result of the project. However, the community health center did increase acceptability and accessibility of the services available to the community. Staffing by community members enhanced acceptability. The community health center is located centrally in the town, assuring community members access to health care.
COMMUNITY EMPOWERMENT, COALITION BUILDING, PARTICIPATION

PROGRAMS

Support groups, and
meaningful involvement of community members in the identification of problems and solutions was key to the project's success. The positive results of the project demonstrate that community involvement in decision-making processes in health care can be effective if it is seen as a commitment by the community and its leaders.

In exit interviews, the community health nurse and promotoras described the importance of meaningful involvement of community members in the decision-making process. They stated that community members felt more empowered and responsible for managing their health care, and that the involvement of the community health center in this process was seen as beneficial.

The involvement of the community in health care and the legislative hearing demonstrate the effectiveness of community empowerment intervention in redistributing power for health care. The hearing proceedings were quite exciting, as people demonstrated a newly developed understanding of health promotion and disease prevention, and the role that nurses and community members have in that activity.

The community health center remains in service 18 months after the phasing out of the project's provision of health care services. The promotoras continue with their work, although two have left their employment for other opportunities.

Distribution and Recommendations

Evaluation of the intervention effect focused on the community as a whole, reflected in participation in decision making affecting health outcomes and health services. However, empowerment of the community health nurse, promotoras, and individual community members was an indicator of what was happening at the larger unit of analysis, the community.

Community data-based goals guided the community empowerment intervention. One goal is that community members continue involvement in community health activities after the project. Changes in the promotoras and other community members as they increased their sense of empowerment may have long-term implications for the community. The experience with implementing a community empowerment intervention reinforces awareness of the importance of the community's role in evaluating outcomes at the aggregate level. On the basis of anecdotal reports by community members, the community empowerment intervention can be said to have resulted in individual experiences of empowerment and a perception of change in the community.

The ultimate benefits of community-level environmental change and political change (Wallerstein, 1992) are outcomes best measured longitudinally. The community empowerment intervention produced short-term improvements in the health care environment and political participation by community members. Long-term effects need further evaluation.

REFERENCES


