Advocacy in Action

Asian Women’s Co-op

A nurse educator working in Southeast Asia spent a year with her clinical nursing students conducting a community survey of the surrounding villages in Ward 13. After completing an assessment and analysis, she concluded that an intervention was necessary to combat the excessive amount of drinking by the village men in this particular community. Her goal was to establish a program similar to Alcoholics Anonymous (AA) that would help the men become sober and therefore more productive members of society. She met with the ward officer and his colleagues to discuss her idea. They all agreed that the men drank excessively but did not agree that these men would be interested in an AA-type program. They felt the time and money might be better spent working with the women in this community.

A meeting was scheduled with several women who were leaders in the community and women interested in discussing an intervention plan. During this meeting, the women were very excited to find someone who was concerned with their needs and had access to the resources they needed. They wanted to learn skills for knitting and sewing to make articles of clothing to sell to tourists. This activity would provide them with their own income and their families with food and other essentials not affordable to them with the money provided by their husbands. They wanted to be self-sufficient and provide a better life for their children. The nurse educator, community women, and ward officer submitted a proposal to a non-governmental organization for funding. The proposal was approved and funded, and the women were given sewing and knitting equipment and supplies. The ward office provided access to a meeting room for the women, and trainers were provided through a local handicraft business. During the training, the women expressed interest in learning about proper nutrition for their children. They also wanted to learn to read and write. Resources were found to provide these services, and the women met in weekly training sessions. Upon successful completion of the training, each woman received a certificate of completion. Thirty women in the district completed the first training in 1994.

Since 1994, the women have continued to learn to sew and knit. They have bought three more sewing machines to supplement the original three from the grant. They have rented their own space in the town to conduct the training, and now training is provided twice daily, 6 days a week. A little bit of money and a lot of motivation changed the lives of many people; these women only needed someone to believe they could fulfill their goals and provide them with the resources to do so. As of 2001, they have been self-sustaining in their women’s skills training center.

Ruth Grubesic
Assistant Professor, Director International Nursing Affairs
Texas Woman’s University
CHAPTER OBJECTIVES

After reading this chapter, you should be able to:

1. Discuss the relationship of community empowerment to other similar concepts.
2. Identify levels of community empowerment.
3. Apply selected models for community empowerment.
4. Describe the process of community empowerment.
5. Apply criteria to evaluate community empowerment.
6. Analyze the role of community health nurses in community empowerment.

KEY TERMS

community building 299
community capacity 299
community competence 299
community development 299
community empowerment 298
issue selection 304
media advocacy 309
participatory evaluation 311
Throughout this book, we emphasize the advocacy role of the community health nurse. Community health nurses act on behalf of individuals, families, and population groups that, for whatever reason, cannot act for themselves. The ultimate outcome of advocacy by community health nurses, however, is the ability of the client to act independently. Community empowerment, as discussed in this chapter, endeavors to accomplish that outcome, to enable communities to identify community health problems and take steps to resolve them independently of or in concert with health care professionals and others. Just as successful nursing education programs prepare graduates to function effectively on their own in the practice milieu, so too does effective community health nursing, as community empowerment, prepare communities to deal with their own health problems and issues.

Although some authors trace the beginnings of community organization and empowerment to the settlement house activities of the late 1800s (Minkler & Wallerstein, 2005), the nurses of the Henry Street Settlement did not engage in community organization or empowerment activities as we know them today. Those nurses certainly functioned as advocates for the health and social welfare needs of the immigrant populations they served, but they did not work to enable those populations to act on their own behalf. On the contrary, they tried to work within the existing power structure to benefit these populations, rather than attempting to redistribute power in their favor. Today’s social change professionals, also called “conscious contrarians” (Minkler, 2005) or “civic revolutionaries” (Henton, Melville, & Walesh, 2004), are characterized by a worldview of people and society that rejects the dominant distribution of social power and chooses community organization or empowerment to foster a redistribution of power (Minkler, 2005).

EMPOWERMENT AND RELATED CONCEPTS

Community empowerment, the topic of this chapter, is closely related to a number of similar concepts. Empowerment is defined as “an enabling process through which individuals or communities take control over their lives and their environment” (Minkler & Wallerstein, 2005, p. 26) or as “the development of understanding and influence over personal, social, economic, and political forces impacting life situations” (Schultz, Israel, Zimmerman, & Checkoway as quoted in Ogilvie, Allen, Laryea, & Opare, 2003, p. 114). Similarly, the World Health Organization (WHO) has defined empowerment as “a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life” (as quoted in Wallerstein, 2002, p. 73).

Community empowerment is the process of “enhancing capacity of communities to control their own lives, effect change, mobilize and use resources, and obtain services to address health problems and collectively counter health risk behaviors and conditions that produce and support them” (May, Phillips, Ferketch, & Verran, 2003, p. 254).

ETHICAL AWARENESS

Minkler and Pies (2005) described a number of ethical issues and practical dilemmas involved in community organizing or empowerment. Some of these issues include conflicting loyalties, funding sources, promoting real participation by community members, cross-cultural issues, the unanticipated consequences of organizing, and questions of the common good.

- Conflicting loyalties may arise when promoting community empowerment is in conflict with the best interests of the health professional’s employing agency. For example, in one community, residents wanted to create another source of health care services. Some of the people assisting with development were employed by a local health care agency that might lose part of its clientele if new services were initiated.

- Available funding sources may mean that community efforts cannot be directed to areas of real interest to the community, but to those that have potential for funding. For example, in one community, the most pressing issues were those affecting senior citizens, but the initiatives for which grant funding was available addressed the needs of children and youth.

- Community participation is often difficult to elicit, particularly in low-income communities where people may work several jobs to make ends meet, leaving them little time to engage in community development initiatives. The health professional is then faced with the necessity to proceed with identified initiatives with less actual community resident participation than desired.

- Multiple cultural orientations within the community and between community members and health professionals provide the potential for cultural misunderstandings and perceptions of racism. Many ethnic groups are not vocal in community organizing processes, and health professionals need to be cognizant of the need to elicit and incorporate their perspectives as well as those of more vocal groups.

- Community organizing efforts may occasionally lead to unanticipated negative consequences. For example, recent news coverage of the campaign to immunize against polio, initiated 50 years ago, had the unintended effect of stigmatizing persons with polio as disabled and focusing negative attention on their disabilities.

- Finally, the “common good” may be defined differently by different segments of the community. For example, local government may see upscale housing as a means of increasing tax revenue to support public services, yet affordable housing may be a greater need for the majority of residents. The question then becomes one of who defines what the common good entails.

How might these ethical considerations influence community organizing activities in your area? What strategies might help address them?
Community empowerment arises from activities related to community development, community organizing, community mobilization, and community building. Empowerment, in turn, leads to increased community capacity and competence. The relationships among these concepts are depicted in Figure 13-1. Community development is often the term used to refer to the rejuvenation of communities through housing and business development (Rubin, 2000). Community development may also be conceived more generally as promoting group action and providing a voice in decision making for disadvantaged groups within the population (Billings, 2000). This perspective on community development is more akin to the concept of community empowerment as discussed in this chapter than to the more traditional view of community development as economic development.

The concept of community organization was presented in Chapter 7 and reflects a process “by which community groups are helped to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they have collectively set” (Minkler & Wallerstein, 2005, p. 26). Community mobilization, a similar term, was defined as a community health nursing role in Chapter 1, and involves “working with individuals and groups to provide population-based community driven assessments, interventions, and evaluations” (Westbrook, as quoted in Westbrook & Schultz, 2000, p. 53). Both of these processes tend to be more problem-specific than community empowerment, which is designed to develop overall community abilities to deal with a variety of problems. Community building is another similar, but more general, process that leads to community empowerment. Community building is defined as “continuous, self-renewing efforts by residents and professionals to engage in collective action, aimed at problem solving and enrichment, that creates new or strengthened social networks, new capacities for group action and support, and new standards and expectations for the life of the community” (Blackwell & Colmenar, 2005, p. 436). Community building efforts frequently lead to increases in community social capital as described in Chapter 10. Another related term is capacity building, which may occur at three levels. The first level of capacity building is that of developing the capabilities of the health infrastructure to deliver needed health care services. The second level is the capacity to maintain and sustain programs when initial funding (usually external funding) is withdrawn. The third level is that of community abilities to address a variety of health-related issues (Labonte & Laverack, 2001).

Community empowerment results in increased community competence and capacity, as depicted in Figure 13-1. Community competence is defined as “the ability of the community to engage in effective problem solving” (Anderson, Guthrie, & Schirle, 2002, p. 43). Community capacity is the “abilities, behaviors, relationships, and values that enable individuals, groups, and organizations at any level of society to carry out tasks or functions and to achieve their development objectives over time” (Morgan, as quoted in Ogilvie et al., 2003, p. 113). The community empowerment literature identifies several domains of community capacity. These include:

- An articulated and shared value system
- Active participation by community residents
- Assumption of leadership roles by community members
- Empowering organizational structures and rich social support networks that provide structures and mechanisms for community dialogue
- Ability to achieve consensus on goals and actions to reach them
- A variety of skills, knowledge, and resources
- The ability to critically reflect on community circumstances and to identify factors underlying community problems
- A sense of community cohesion, commitment, and trust
- The ability to mobilize resources to address community problems
- An understanding of community history and its influence on community action or inaction
- Access to power
- Links to others as resources outside the community
- Equitable relationships both within and outside the community
- Community control over decisions and programs
- The ability to engage in strategic planning for future development (Eng & Parker, 2002; Norton, McLeroy, Burdine, Felix, & Dorsey, 2002; Tones & Green, 2004; Wallerstein, 2002)
GLOBAL PERSPECTIVES

Ogilvie et al. (2003) described international capacity building as the efforts of people in one country to help those in another achieve their objectives. Examine the news media to identify examples of international capacity building or empowerment related to health issues. Who is providing the assistance? Who is receiving it? Based on the examples you have found, does capacity building always flow from the “haves” to the “have nots”? In what ways could underdeveloped nations contribute to international capacity building? As one example, what could the United States learn from countries with low neonatal death rates that could decrease U.S. neonatal mortality?

LEVELS OF EMPOWERMENT

Empowerment may occur at a variety of levels. Two of the possible levels are those of the individual community member and of the community at large. Individual empowerment focuses on improving individual skills and self-esteem as a precursor to taking control of one’s own life. Community empowerment focuses on increased civic participation and preparation for collective action to address common concerns or achieve common goals (Anderson et al., 2002). Individual empowerment is a process of increasing one’s power to take action to improve one’s own life (Askey, 2004). Individual empowerment may address one or more of three areas of personal development: (a) intrapersonal components, such as perceived control and self-efficacy; (b) interactional components related to transactions between people and with the environment; and (c) behavioral components related to the development of specific actions and skills (Ogilvie et al., 2003).

Community health nurses may be involved in both individual and community empowerment. For example, a nurse may assist an abused woman to obtain job training and to request a restraining order against her abuser, empowering her to leave the abusive situation. At the community level, a community health nurse might assist residents of a low-income neighborhood to collect information on gang-related criminal activity and present a petition to the City Council requesting a greater police presence in the neighborhood.

Community empowerment may also occur at horizontal and vertical levels (Wallenstein, 2002). Horizontal empowerment is internal to the community and is reflected in the community’s ability to solve problems by mobilizing its own resources. This level is related to what is termed “locality development” or the empowerment of local communities to make change (Dregradahl, 2002). For example, a community health nurse might help neighborhood residents to form a neighborhood watch group to help control gang activity. Vertical empowerment involves efforts to change power structures outside the community and to leverage outside power and resources to address community concerns and may involve organizing marginalized groups to make demands on the larger society. Vertical empowerment is reflected in the previous example of petitioning the City Council for better police coverage. Finally, community empowerment may be conceived as occurring along a continuum from personal empowerment to the development of small mutual support groups, to the development of community organizations, to the creation of coalitions and linking with outside resources to address community concerns (Laverack, 2004; Uys, Majumdar, & Gwele, 2004). At the level of personal empowerment, a community health nurse might help a homeless man with a substance abuse problem find work and enroll in a recovery program. At the next level, the nurse might assist a group of homeless individuals to form a support group that permits them to share knowledge of resources. Helping to create an organization composed of homeless individuals and families and members of the social services community to address the health care needs of the homeless population would be an example of the third level of empowerment. Finally, at the fourth level, the community health nurse might assist the community organization to link with legal advocates and others to promote legislation to protect the civil rights of homeless individuals.

MODELS FOR COMMUNITY EMPOWERMENT

The dominant framework for community organizing or empowerment work is Rothman’s work in the 1970s addressing three levels of practice: locality development, social planning, and social action. Locality development involves development of a sense of community and a group identity. Social planning focuses on the resolution of specific problems identified in the community, and social action is geared toward increasing the problem-solving ability of the community in general. Most models on which community empowerment activities are based involve a combination of these levels (Minkler & Wallerstein, 2005). Some of the models to be discussed here include the Community Action Model (Lavery et al., 2005), the Nursing Model of Community Organization for Change (Anderson et al., 2002), the Community Organization Model (Tones & Green, 2004), and the Planned Approach to Community Health (PATCH) model (Butler, 2001). Elements of each of these models are compared in Table 13-1. As can be seen in Table 13-1, each of the models incorporates components similar to those of the nursing process, usually addressing some sort of community assessment, diagnosis, or analysis; goal development; selection and implementation of appropriate intervention strategies; and evaluation of the outcomes achieved. The table also includes examples of ways in which community health nurses could be involved in community empowerment in the context of each model.
<table>
<thead>
<tr>
<th>Community Action Model</th>
<th>Nursing Model of Community Organization for Change</th>
<th>Community Organization Model</th>
<th>PATCH Model</th>
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</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td>Assessment/reassessment</td>
<td>Community analysis</td>
<td>Mobilize the community</td>
</tr>
<tr>
<td>• Train a few essential community members</td>
<td>• Identify felt needs, assets from community perspective and with community involvement</td>
<td>• Define community</td>
<td><strong>CHN involvement:</strong> Help to identify appropriate community members as participants.</td>
</tr>
<tr>
<td>• Identify the issue</td>
<td>• CHN involvement: Assist community members to design and conduct community needs/asset assessment.</td>
<td>• Develop a community profile</td>
<td>Collect and organize data related to the issue</td>
</tr>
<tr>
<td>• Choose a meaningful focus for the issue</td>
<td><strong>Planning/design</strong></td>
<td>• Assess community capacity</td>
<td><strong>CHN involvement:</strong> Assist community members to design and conduct community needs/asset assessment.</td>
</tr>
<tr>
<td></td>
<td>• Establish goals to be achieved</td>
<td>• Assess barriers to action</td>
<td>Choose health priorities</td>
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<td></td>
<td>• Design interventions to achieve them</td>
<td>• Assess readiness for change</td>
<td><strong>CHN involvement:</strong> Assist community members to prioritize issues and select one for action.</td>
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<td></td>
<td><strong>CHN involvement: Assist community members to develop data categories and collection methods regarding factors contributing to the issue and the effect of the issue on the community</strong></td>
<td><strong>Design initiation</strong></td>
<td>Develop a comprehensive intervention plan with multisectoral collaboration</td>
</tr>
<tr>
<td></td>
<td><strong>CHN involvement: Assist community members to develop data categories and collection methods regarding factors contributing to the issue and the effect of the issue on the community</strong></td>
<td>• Develop an organizational structure</td>
<td><strong>CHN involvement:</strong> Assist community members to determine desired outcome of action, to identify and evaluate possible alternative approaches to action, and to develop specific strategies for the alternative selected.</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td><strong>Implementation</strong></td>
<td>• Develop a core planning group and identify a coordinator</td>
<td>Evaluate the effectiveness of interventions</td>
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<tr>
<td>• Conduct community diagnosis of root causes of the issue</td>
<td>• Implement the actions designed to achieve the identified goals</td>
<td>• Recruit members</td>
<td><strong>CHN involvement:</strong> Assist community members in the development of criteria to measure success and data collection methods and in analyzing evaluative data in light of desired outcomes.</td>
</tr>
<tr>
<td>• Assess the extent of the effect on the community</td>
<td><strong>CHN involvement: Educate community members, as needed, on how to implement selected actions; assist community members to develop mechanisms to monitor implementation and progress toward goal achievement.</strong></td>
<td>• Define goals</td>
<td></td>
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<tr>
<td></td>
<td><strong>CHN involvement: Assist community members to determine desired outcome of action, to identify and evaluate possible alternative approaches to action, and to develop specific strategies for the alternative selected.</strong></td>
<td>• Clarify roles and responsibilities</td>
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<tr>
<td><strong>Step 3</strong></td>
<td><strong>Implementation</strong></td>
<td>• Provide training and get recognition</td>
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<tr>
<td>• Analyze diagnostic results</td>
<td><strong>Implementation</strong></td>
<td>• CHN involvement: Help identify potential planning group members; educate planning group members in group process and guide progression in the steps of group development; assist community members to develop and disseminate information messages related to planning.</td>
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<tr>
<td></td>
<td><strong>Implementation</strong></td>
<td>• Develop interventions</td>
<td></td>
</tr>
<tr>
<td>• CHN involvement: Assist community members to analyze data and identify key contributing factors as a target for action</td>
<td>• Develop timeline</td>
<td>• Develop timeline</td>
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</tr>
<tr>
<td><strong>Step 4</strong></td>
<td><strong>Implementation</strong></td>
<td>• Generate broad community participation</td>
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<td>• Select, plan, and implement actions to address the issue</td>
<td><strong>Evaluation/dissemination</strong></td>
<td>• Plan media coverage</td>
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<tr>
<td>• Identify desired outcomes to be achieved</td>
<td>• Identify successful and unsuccessful elements</td>
<td>• Obtain financial and other support</td>
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<tr>
<td><strong>CHN involvement:</strong> Assist community members to identify and evaluate possible alternative approaches to issue resolution and</td>
<td>• Disseminate information to community to promote decision making</td>
<td>• Develop evaluation plans</td>
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</tbody>
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**Continued on next page**
### TABLE 13-1  Elements of Selected Community Empowerment Models and Examples of Community Health Nursing (CHN) Involvement (continued)

<table>
<thead>
<tr>
<th>Community Action Model</th>
<th>Nursing Model of Community Organization for Change</th>
<th>Community Organization Model</th>
<th>PATCH Model</th>
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<tr>
<td><strong>Step 5</strong></td>
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<tr>
<td>• Enforce or maintain the action or activity</td>
<td>CHN involvement: Assist community members in developing criteria to measure success and data collection methods, in analyzing evaluative data in light of desired outcomes, and in writing messages for dissemination.</td>
<td>CHN involvement: Assist community members to recognize successful endeavors and progress toward achieving outcomes; assist with writing grant proposals to sustain community activities; help to identify and recruit additional participants; assist community members to plan events to recognize contributions made.</td>
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<tr>
<td>CHN involvement: Assist community members to develop mechanisms to monitor ongoing activity and results (e.g., changes in the issue or its effects on the community); link community members to agencies or organizations that will enforce action (e.g., housing authority or City Planning Commission).</td>
<td>Dissemination/reassessment</td>
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<tr>
<td></td>
<td>• Update community analysis</td>
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<tr>
<td></td>
<td>• Assess effectiveness of interventions</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Summarize and disseminate findings</td>
<td></td>
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<tr>
<td></td>
<td>CHN involvement: Assist community members to develop criteria to measure success, to select data collection methods, to analyze evaluative data in light of desired outcomes, to develop strategies to disseminate evaluation findings and to determine directions for future action based on findings.</td>
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One additional type of model that may be employed is the natural helper model. This model differs from those presented in Table 13-1 in that it is not a process model but focuses on the use of natural helpers within the community to promote community empowerment. Natural helpers are “particular individuals to whom others naturally turn for advice, emotional support, and tangible aid” (Eng & Parker, 2002, p. 126). Several types of informal helpers may exist in a community. Among these are family, friends, and neighbors, natural helpers, role-related helpers, people with similar problems, and volunteers. The role of friends, family, and neighbors as informal helpers is well understood, and the category of natural helpers has been defined above. Role-related helpers are people who, because of their role in the community, can provide help in certain circumstances. For example, educated shopkeepers could assist clients to make healthy food choices or could be sources of information and referral in other health-related areas. People who have similar kinds of problems can form self-help and support groups and share group resources, knowledge, and skills. Volunteers are people who are willing to provide their time and energy to specific initiatives or program efforts. Natural helpers are not the same as community health workers (CHWs), who are members of a community with some training hired by community agencies to work directly with their fellow residents. We will discuss the use of community members as health workers later in this chapter.

ORGANIZING FOR COMMUNITY EMPOWERMENT

As we can see, based on the models included in Table 13-1, the process of community empowerment is very similar to the nursing process. In this chapter, we will address some of the aspects of that process, focusing on assessment, planning, strategies for implementation, and evaluation.

Assessing Communities

Community organizing and empowerment initiatives may take one of two approaches or a combination of both. The first, and more traditional, approach is to focus on community needs and needs-oriented solutions. The second approach is capacity-focused and involves developing individual and group capacities or assets as the first step in community rejuvenation (McKnight & Kretzmann, 2005). A combined approach examines both community needs and community assets.

Community assessment, in the context of community empowerment, has two general purposes. The first is to provide information for change—facts about the current situation, contributing factors, and assets that may be brought to bear to facilitate change. The second purpose is to provide information for empowerment. As the old adage states, “knowledge is power,” and communities need knowledge in order to assess the situation and take action (Hancock & Minkler, 2005). The same elements of community assessment data can contribute to the achievement of both purposes. Community assessment may also result in several other indirect effects for community empowerment, including the creation of social cohesion among community members, encouragement of self-help within the community, persuasion for change, and identification and development of local leadership. Additional effects of community assessment may include development of civic consciousness and a sense of responsibility for community welfare, identification of professional and technical support for local initiatives, better coordination of existing services to meet local needs, and training in democratic processes, leading to decentralization of some government functions (Clinard, cited in Kennedy & Crosby, 2002).

The actual assessment of the community can be framed in terms of the dimensions of health from the dimensions model, examining factors in each of the six dimensions that reflect community assets or that contribute to community needs. The specifics of such an assessment are addressed in detail in Chapter 15. Some of the areas that might be examined in a community empowerment assessment are quality-of-life indicators, “provocative indicators,” community processes and their effects on health, and formal and informal leadership within the community. Provocative indicators are those for which there may not be valid and reliable data, but that make people think and take notice of an issue (Hancock & Minkler, 2005). In one community assessment, for example, community members repeatedly expressed perceptions of poor care provided by a local community clinic. Although these perceptions were not accurate, they forced clinic administrators to examine how their services were perceived in the community and to make changes in service delivery to improve their image among community members.

In the context of community empowerment, asset data from the community assessment can be organized in terms of three levels of “building blocks” that contribute to community regeneration. At the first level are the primary building blocks, those that are under the direct control of the community. Primary building blocks include the talents of individual community members, personal income, local businesses (including in-home businesses), and community associations and organizations and their capacities. These may include business, religious, cultural, citizens’, communications, and other organizations and associations within the community (McKnight & Kretzmann, 2005).

Secondary building blocks are located within the community but controlled by outsiders. These may include private and nonprofit organizations (e.g., a private university or hospital, banks), public institutions.
and services (e.g., the local health department), and the physical resources of the community (e.g., vacant land). The third level of building blocks includes potential building blocks located outside the community and controlled by outsiders. Examples of potential building blocks are welfare funding, capital improvement funds, and public information (McKnight & Kretzmann, 2005).

Community health nurses can help members of the community to conduct an assessment as a first step in community empowerment. For example, the nurse can assist community members to identify relevant categories and sources of data needed and to develop effective data collection strategies. In addition, the nurse can help community members analyze assessment data and identify factors that impede and facilitate community empowerment. Clark et al. (2003) provided an example of a community health nurse facilitating resident involvement in a community assessment. In this process, the community health nurse assisted community members to conduct focus groups among multiple segments of the community to identify community needs and assets. The findings of the assessment were shared with the wider community and became the impetus for a variety of community-initiated efforts to improve living conditions in the community.

### Planning Considerations

Capacity-oriented community empowerment planning is characterized by three elements. First, it incorporates as many internal community resources as possible. Second, it is based on the results of a community capacity inventory or assessment of community assets. Finally, community building strategies will build on community assets (McKnight & Kretzmann, 2005).

Community empowerment planning also poses several challenges to the social change professional or community health nurse. These challenges include:

- Reconciling individual and community needs by creating common purposes, values, and complementary roles.
- Reconciling trust and accountability. Community members must trust each other and outside assistance, yet demand that persons responsible for action on behalf of the community are accountable for their actions.
- Reconciling economic and social goals by creating a cycle of renewal in which strengthening local business and economic interests also strengthens the social fabric of the community and vice versa.
- Reconciling people and place by recognizing and addressing diversity among community members whose needs may not all be the same despite their residence in the same community.
- Reconciling change and continuity by moving from expectations of stability to acceptance of change as a given. There is a need to recognize and accept that turnover will occur among participants in community organizing activities and to work to maintain stability of function in spite of turnover.
- Reconciling idealism and practicality by supporting the core values of the community in the context of the constraints imposed by the reality of the situation. Community members need to continually strive toward the ideal, but be willing to accept incremental changes in achieving it (Henton et al., 2004).

Specific elements in the process of planning for community empowerment are similar to those in planning any community initiative or program and are addressed in more detail in Chapter 15. Here we will focus on three aspects of planning that are particularly relevant for empowerment planning: issue selection, team building, and coalition development.

### Issue Selection

Issue selection is a critical element in planning for community empowerment. **Issue selection** involves “identifying winnable and specific targets of change that unify and build community strength” (Minkler & Wallerstein, 2005, p. 35). Issues in community empowerment are selected not only on the basis of community needs but also for their value in fostering community leadership development (Staples, 2005). Potential criteria for issue selection are reflected in the focused assessment questions below.

There are four basic considerations in developing the initial outline of an issue (Staples, 2005). The first of these is constituency. Who are the constituents or parties...
interested in the issue? What is the source of their interest? The second consideration is the goals of constituents with respect to the issue. What do constituents hope to accomplish in addressing the issue? Potential targets for action are the third consideration in framing an issue. Who will decide the issue? Who can influence those who will decide the issue? The final consideration addresses the question of how leverage can be gained with respect to the issue and suggests direction for the empowerment effort. For example, is legislation the best approach to resolving the issue, or are there other avenues for addressing the issue that would be more effective than legislation? Continuing with the example from Clark et al. (2003), the community health nurse reported the assessment findings to members of the community at large at a community forum. Housing was one issue that cut across all of the focus groups participating in the assessment. The constituency for this issue included most of the members of the community. Potential targets for action, in this case City Council members, members of the County Board of Supervisors, and representatives of the housing authority, were also invited to the community forum. As a result of the forum, a community group was formed, with the support of public officials, to address local housing issues in several ways, including passage of city ordinances that protected tenants from intimidation and exploitation by landlords.

**Team Building**

Community empowerment is a group effort that requires activity by a team of committed individuals. Team members must not only be committed to the effort but must also have the ability to work effectively as a team. Two aspects of team building involve motivating community participation and actual development of the group.

**MOTIVATING COMMUNITY PARTICIPATION** Community empowerment, of necessity, requires participation by community members in all facets of issue identification and action to resolve identified issues. Authors have identified eight levels of community participation. The first two levels, manipulation and therapy, actually reflect nonparticipation, in which clients and communities are passive targets of interventions without having input into decisions regarding those interventions. The next three levels reflect token participation: informing the community regarding potential actions or interventions, consulting with members of the community in designing actions, and placating community members by listening to their input but not necessarily incorporating it into decisions. The three last levels of participation are considered true participation and reflect reallocation of power to community members. The first of these is partnership, in which community members and decision makers have joint authority for decisions and action. The second is delegated power, in which the decision-making authority has delegated power for certain decisions to community members. At the highest level, citizen power, community members have control over the issue and all decisions or intervention programs related to it (Arnstein, cited in Broadnax, 2000). A similar continuum of participation has been identified for consumer involvement in health care delivery from information giving to true empowerment (McKenna & Keeney, 2004).

From an empowerment perspective, the last level of community participation is the most desirable, and movement toward this level should be an ultimate goal of empowerment activity. Participation by community members even at lower levels, however, may be difficult to achieve for a number of reasons (Merzel & D’Afflitti, 2003). Community members may have other competing concerns or uses for their time. For example, one community empowerment initiative centered on the development of community health councils, grassroots groups charged with identifying community health concerns and bringing them to the community collaborative for collective action. In this impoverished community, however, almost all of the adults were working, many at...
BUILDING OUR KNOWLEDGE BASE

Design a study to determine what factors influence the participation of community members in community empowerment initiatives. What type of study would you conduct? What criteria would you use for selection of your subjects and how might you recruit people who meet those criteria to participate in your study? What data collection strategies would you use, and how would you analyze your data? What do you think your findings might indicate, and how could your findings be used to enhance community participation in empowerment activities?

multiple jobs, and had little time to spare for work in the health councils.

Community members may also have different priorities from those of community organizers or health care professionals. If the community empowerment initiative, however, is based on a sound assessment of community needs and assets, social change professionals will be able to identify community priorities and incorporate them into issue selection as discussed earlier.

Another deterrent to community participation may be perceived lack of community control of decisions and resources. This rather fatalistic attitude may be a cultural factor or the result of past experience trying to influence factors affecting community health status. Community members may also have experiences of exploitation by outsiders, which may limit their enthusiasm for community participation activities (Markens, Fox, Taub, & Gilbert, 2002). Use of asset assessment data may help to convince community members of their ability to make changes through participation. Successful resolution of community issues, based on the criteria for issue selection addressed above, will also help to reduce this barrier to participation in subsequent community initiatives. Fears of exploitation will only be resolved by the development of trust and seeing that activities do indeed benefit, rather than exploit, the community.

The volunteer nature of community participation is another factor to be considered. People may agree to participate in initiatives related to specific personal interests but not be interested in continuing to participate in other initiatives. This is why it is particularly important to address the challenge of stability versus change in community empowerment activities. Participants are likely to change over time, and that change must be accommodated without losing the momentum of community empowerment activities.

Finally, widespread participation may be hampered by the lack of sufficient time to engage multiple stakeholders with competing priorities. As noted earlier, one of the challenges in community empowerment is to create shared purposes and values and develop complementary, rather than competing, roles for participating segments of the community. However, this effort takes time that may not be available in addressing time-sensitive issues. As we noted in Chapter 7, there may be a window of opportunity for addressing an issue that requires rapid movement and action within the available time frame.

Even when community members are willing and able to participate in community empowerment activities, they often lack the requisite skills and abilities to do so. There is frequently a need to engage in specific team-building activities to meld a cohesive community group prior to initiating any action. Effective teamwork requires a shared team culture, open communication, and mutual respect and value for the opinions and contributions of others. Development of such a milieu requires the nurturing of group process and the development of group dynamics outside the context of community action related to specific issues (Scholes & Vaughan, 2002). Returning to the housing example, the local neighborhood committee joined forces with a citywide organizing project to work on the issue of safe and affordable housing. At the same time, community residents were invited to participate in a course popularly called “Community Organizing 101,” offered by the local university to develop community organizing and empowerment skills. Community health nurses participated as part of the multidisciplinary faculty for the course, assisting residents to identify and strategize to resolve other community health-related issues.

STAGES OF GROUP DEVELOPMENT Group development occurs in a series of stages: orientation, accommodation, negotiation, operation, and dissolution. These stages parallel the components of the nursing process, as indicated in Table 13-2. Specific tasks must be accomplished during each stage of group development for the group to function effectively.

Orientation The orientation stage of group development, sometimes referred to as the “forming stage” (Drinka & Clark, 2000), is when group members come to know each other and assess their ability to function as a group. Tasks of this stage include selection of group members, training them for group participation, and identification of group goals and purposes. Also during this stage, the group assesses community empowerment needs and community assets.

Development of group-related skills in the context of community empowerment includes cognitive and
social interaction skills (Tones & Green, 2004). Cognitive skills required for community members to be empowered include literacy skills and decision-making and problem-solving skills, as well as knowledge of political processes. Requisite social interaction skills include life skills and assertiveness skills as well as skill in talking to policy makers and motivating others. Community health nurses who possess these skills can assist other group members in their development. In addition, community health nurses can educate group members regarding group processes and guide members through the stages of effective group development.

Accommodation The accommodation (or “norming”) stage of group development focuses on the development of group dynamics, the ways in which the group will carry out its group-related functions. This does not relate to activities the group will undertake to resolve any identified community issues, but to the ways in which the group itself will operate. Tasks in this stage include developing an atmosphere conducive to group collaboration and establishing modes of group decision making, conflict resolution, and communication.

Group action requires group decisions, and decisions must be made after careful consideration by group members. To facilitate decision making, group members should agree on the method by which decisions will be made. Because most people are not familiar with group processes or the deliberate need to select a decision-making strategy, the community health nurse may need to guide the group in this task.

Decisions can be made in one of six ways: by default, by the leader, by a subgroup, by majority vote, by consensus, or by unanimous consent. Decisions made by default result from a lack of response by the group. The second method of decision making, in which decisions are made by the leader, is appropriate when a decision cannot wait on the slow-moving democratic process (e.g., when there is an emergency). The group may decide to give the group leader authority to make independent decisions in certain circumstances, but should decide in advance what those circumstances will be. In an effective group, this is not the method used for making most of the group’s decisions.

In the third approach to group decision making, group decisions are made by a subgroup. This might involve “railroading,” in which the subgroup uses its power and influence to force a decision on other group members. Conversely, the larger group may purposefully delegate the making of certain decisions to a subgroup. Many nursing organizations, for example, delegate authority to an executive board for decisions regarding everyday operation and make only major decisions as a total group.

Majority vote by group members, the fourth method of decision making, is already familiar to us. The fifth method involves consensus or agreement by all group members despite any reservations that individual members might have. Finally, decisions may be made by unanimous consent, in which all group members agree without reservation. In both the consensus and unanimous consent methods, the group may take a relatively long time to reach a decision because of the need for all members to agree. For the purposes of community empowerment, majority vote, consensus, and unanimous consent are the most appropriate methods for group decision making.

### TABLE 13-2 Tasks of Group Development by Stage and Related Nursing Process Component

<table>
<thead>
<tr>
<th>Nursing Process Component</th>
<th>Stage of Group Development</th>
<th>Group Development Tasks</th>
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</table>
| Assessment and diagnosis  | Orientation (forming)     | 1. Selection of group members  
2. Training for group participation  
3. Identification of goals and purposes |
| Planning                  | Accommodation (norming)   | 1. Establishment of modes of decision making  
2. Development of mechanisms for conflict resolution  
3. Development of communication network  
4. Development of climate conducive to group collaboration |
|                           | Negotiation (norming)     | 1. Negotiation of member roles  
2. Development of methods of task assignment |
| Implementation            | Operation (performing)    | 1. Assignment of specific tasks to accomplish group goals  
2. Performance of actions to accomplish goals |
| Evaluation                | Dissolution (leaving)     | 1. Planning of evaluative mechanisms for outcomes of action taken  
2. Assignment of member roles and tasks in evaluation  
3. Data collection  
4. Analysis of evaluative findings  
5. Possible group dissolution |
Establishing modes of group conflict resolution is the second task in the accommodation stage of group development. Breakdowns in the decision-making process are one source of conflict within the group. Other potential sources of conflict are unclear expectations, poor communication, differing values or attitudes, and competition for scarce resources (Habel, 2000). Lack of clear jurisdiction among group members and conflicts of interest may also be sources of conflict within the group. Additional sources of conflict are interdependence when needs are not met and the existence of prior unresolved conflict between members or subgroups.

Conflict is a normal component of group effort and is to be expected. In fact, many group behavior theorists include a conflict or “storming” stage in describing the development of groups over time (Drinka & Clark, 2000). If the group has developed mechanisms for conflict resolution before conflicts arise, conflict can often be a positive rather than divisive experience for the group.

Recognition of conflict as a normal phenomenon is essential if the group is to plan ahead for conflict resolution. Again, many groups do not anticipate conflict, and when conflict occurs they are unprepared to deal with it. Strategies for resolving conflict constructively involve creating a climate in which disagreement is acceptable, where all parties can minimize or resolve conflict. Conflict resolution requires that all parties be able to express their perspectives through open communication. Open communication cannot take place when there is pressure to conform and lack of acceptance of different opinions. Lack of communication hampers conflict resolution as well as contributing to conflict. As a group leader, the community health nurse may need to encourage group members to express thoughts and opinions that may not be congruent with those of other members. Through the use of interpersonal skills, the nurse can ensure that communications within the group are not accusatory, but deal with issues rather than personalities.

Recognizing the existence of conflict and identifying its sources and possible solutions are strategies for constructive use of conflict. A conflict that is ignored in the hope that it will resolve itself is likely to become worse. The community health nurse can encourage other group members to acknowledge that a conflict exists and help them explore the reasons for conflict. Again, the nurse should be alert to covert signs of conflict and bring them to the attention of the rest of the group. For example, a nurse working with a group trying to determine budget allocations among health care programs within the county may notice that representatives of programs for the elderly are maintaining a stony silence during the discussion. The nurse may comment on the fact that they have not participated in the discussion and ask why. In the ensuing discussion, it may be learned that these group members feel that too much money is being allocated to maternal–child health programs and that the elderly are being shortchanged. Once this conflict has been exposed, the group can begin work to resolve it.

Another strategy for resolving conflict involves identifying small areas of trust and agreement between group members that can be expanded. For example, although two group members may disagree on the “appropriate” approach to a problem, they can capitalize on their shared concern for clients’ welfare. Finally, rational consideration of alternative solutions to a particular conflict using the group’s decision-making process and problem-solving process can result in conflict becoming a valuable learning experience in group problem solving. The community health nurse can assist the group to explore a variety of alternative solutions to a conflict and to select an approach that is agreeable to all members.

Developing group communication strategies is another task in planning group operation. The importance of an effective communication network cannot be overemphasized. The group must develop a common language that facilitates communication, and members should refrain from using jargon familiar only to members of their own discipline. When it is necessary to use terminology unfamiliar to others, efforts should be made to translate it into the common language. The nurse in this situation can either play the part of the translator or ask other members for clarification. For example, some members of a group may use acronyms unfamiliar to others, such as CMS. The nurse should explain to the group that this stands for the Centers for Medicare and Medicaid Services. If the nurse does not recognize the acronym, he or she would ask for an explanation of its meaning.

The group should also agree on the form that communication will take. For example, communications may be verbal, written, or a combination of both, depending on the situation. Perhaps the group will decide that communication with sponsoring institutions should take the form of formal written memoranda, whereas communications between group members should be more informal verbal messages.

Consideration should also be given to the fact that communication takes place outside of regular group sessions. The content of these informal encounters between group members should not undermine group function or provide a forum for airing grievances or denigrating other members. The community health nurse who encounters unproductive communication outside of group meetings can bring relevant issues to
the attention of the entire group so open discussion can take place and conflict can be avoided or resolved.

Establishing a climate in which group members feel respected and in which differences are accepted contributes to an effective communication network. This means that all group members should be encouraged to participate and should receive positive reinforcement for their contribution whether or not others agree with it. In the beginning of the group’s operation, the nurse group leader may need to ask reluctant group members for their ideas and opinions. As their participation is received positively, they will begin to volunteer remarks.

**Negotiation** Tasks of the negotiation stage of group development include role negotiation and methods of task assignment. Professional roles often overlap, and role negotiation is crucial to effective group function. In addition, social change professionals working in a community empowerment context need to be careful not to usurp roles that should be performed by community members. The goal of community organizing and empowerment is to develop leadership within the community, not to provide that leadership (Pilisuk, McAllister, Rothman, & Larin, 2005). When two or more group members possess similar skills, the group must decide who will be responsible for exercising those skills. These decisions may be made as a general rule of thumb, so that one member always has responsibility for certain activities, or may change with the needs of the situation.

One particular group role that must be negotiated is the role of leader. This position incorporates functions related to group administration, liaison with outside groups, teaching, and coordination of group effort. Additional team leadership roles may include providing information for group decision making, clarifying issues, refocusing the group’s attention, and playing “devil’s advocate” to promote exploration of alternative ideas. The leadership role may be assigned to one member, may shift with the situation, or may reside with the group as a whole. In the last instance, no one member acts as the leader, and leadership functions are performed by the group as a unit.

**Operation and Dissolution** The operation stage of group development is analogous to the implementation stage of the nursing process. It is during this stage that the group assigns and performs specific roles and tasks to achieve group-designated goals and objectives.

The dissolution stage of group development focuses on evaluation of the group’s accomplishments and decisions regarding the continuation or dissolution of the group. Depending on the focus of group empowerment initiatives, the group may shift its focus to address other community issues after achieving its original purpose. Or it may dissolve to reform with other participants to address additional issues. Tasks of the dissolution stage of group development include planning evaluative mechanisms related to both the process and outcomes of community empowerment, assignment of member roles in evaluation, data collection and analysis, and dissemination of findings. Evaluation of community empowerment activities will be discussed in more detail later in this chapter.

**Coalition Development**

The advantages and disadvantages of coalitions and the steps in their development were presented in Chapter 7. A coalition is “an organization of individuals representing diverse organizations, factions, or constituencies who agree to work together in order to achieve a common goal” (Wandersman, Goodman, & Butterfoss, 2005, p. 293). In the context of community empowerment, coalition development consists of four components: resource acquisition, development of a maintenance subsystem, production, and goal attainment (Prestby & Wandersman, as cited in Wandersman et al., 2005). Resource acquisition involves recruiting coalition members as well as acquiring external resources. The maintenance subsystem consists of the organizational control structure described in Chapter 7 and strategies to maintain member commitment and mobilize members’ resources. The production component involves action strategies to facilitate community empowerment and maintenance of the coalition’s internal structure (e.g., disseminating meeting minutes, promoting communication between members). The goal attainment component is relatively self-explanatory except that it also includes development of a “track record” of successes in community empowerment.

Because of their varied interests and interactions in the community, community health nurses can be particularly helpful in identifying potential coalition members and initiating contacts with potential members. For example, because of her role as a member of the advisory committee for a home health agency, the community health nurse may be acquainted with individuals and organizations that would be interested in collaborating on efforts to provide transportation services for disabled individuals.

**Implementation Strategies**

Implementation of community empowerment activities encompasses the basic principles of implementing any community program. These principles will be discussed in detail in Chapter 15. Here we will briefly address two possible strategies that may be used in implementation, media advocacy and the use of community workers.

**Media Advocacy**

According to the U.S. Department of Health and Human Service (USDHHS), media advocacy is defined as “strategic use of mass media to advance a social or public policy agenda” (Wallack, 2005, p. 423). Media advocacy was discussed in the context of public policy
development in Chapter 7. It is appropriate to make a few more comments about media advocacy as it relates to community empowerment. Media advocacy fulfills the function of drawing attention to an issue and promoting its inclusion in a policy agenda. Attention may also be drawn to the power inequities among segments of society, setting the stage for empowerment initiatives.

A second function of media advocacy is to focus attention on factors contributing to issues of concern (Wallack, 2005). In the context of community empowerment, media coverage may also highlight causal factors in power inequities and suggest ways to empower communities. Finally, media advocacy may be used to advance a particular strategy as a solution to an identified problem. In the case of community empowerment, that might entail policy strategies that empower communities. For example, media coverage might highlight the lack of community involvement in community planning decisions and advocate appointment of community representatives as members of the local planning board as a strategy for addressing the problem. As another example, a community health nurse might help to organize a “tent city” media event with tents pitched in local parks to highlight the plight of low-income renters being displaced by high-income condominium conversions. Community health nurses can cultivate media contacts and identify areas of interest of specific media. Then when an issue requires media attention, the nurse can assist community residents to develop newsworthy perspectives to be shared with radio, television, or newspaper personnel.

Using Community Workers
The concept of community member participation in all facets of community empowerment, from assessment to evaluation, was presented earlier. Community health workers are “carefully chosen community members who participate in training that enables them to promote health in their own communities” (Farquhar, Michael, & Wiggins, 2005, p. 597). Use of CHWs in community empowerment, as well as in health care delivery programs, necessitates training them as resources for peers, linking them to service providers and community leaders, and supporting them in actions to resolve community problems (Eng & Parker, 2002). Use of CHWs has been found to be effective in a variety of situations outside of community empowerment activities. For example, in one study, use of CHWs led to a reduction in asthma symptom days and urgent-care service use and improved quality-of-life scores for children with asthma (Krieger, Takaro, Protests or marches may be one way of raising consciousness regarding important health issues. (© Bob Daemmrich/The Image Works)
In the chapter, we noted two studies of the use of community health workers (CHWs) and their effectiveness in achieving community health-related goals (Farquhar et al., 2005; Krieger et al., 2005). Seek out additional literature related to the use of CHWs. Do the balance of studies indicate their effectiveness or their ineffectiveness? If the research literature supports the effectiveness of CHWs as described in the chapter, how might the CHW concept be incorporated into community health initiatives in your community?
community members able to mobilize internal and external resources to address areas of concern? These and other questions can be used to assess community progress in each of the domains of community capacity.

A final measure of the effectiveness of community empowerment efforts would be the extent to which community members are included in policy making. The ultimate goal of effective community organizing and empowerment should be the inclusion of community members in every aspect of policy making (Blackwell, Minkler, & Thompson, 2005).

COMMUNITY HEALTH NURSING AND COMMUNITY EMPOWERMENT

Community health nurses can be active proponents of and participants in community empowerment. Unfortunately, in the past, community health nurses and other health professionals have been guilty of imposing their values and perceptions of need on communities rather than empowering communities to act for their own benefit (Broadnax, 2000). In a British study of general practitioners (GPs’s), community health nurses, and the general public, 100% of GPs and members of the public and 97% of community health nurses agreed that work toward community empowerment was a critical role for community health nurses, but one for which they are largely unprepared. Study recommendations included the need for community health nurses to ask community members what they want with respect to their health. The authors also recommended work by community health nurses to increase public involvement in the planning and delivery of health services, involve consumers in community capacity building, and motivate policy makers to include community members as equal participants in decision making (McKenna & Keeney, 2004).

Health care professionals, including community health nurses, play an advisory and facilitative role in community empowerment. This role is temporary and catalytic (Anderson et al., 2002). As noted earlier, the purpose of community empowerment is to develop leadership within the community rather than to lead. The influence of community health nurses in community empowerment lies in enactment of three roles: discovery, decision, and drive (Henton et al., 2004). The discovery role involves making community members aware of the need for empowerment and building a compelling case for change in the status quo. Because of their visibility in and knowledge of the community, community health nurses are admirably situated to identify community problems and to promote community participation in their resolution. In the decision role, community health nurses assist community members to determine potential alternative strategies, to evaluate them, and to select the strategies most likely to contribute to achievement of community-identified goals. In the drive role, community health nurses assist in mobilizing the community for change.

Core functions of community empowerment practice for community health nurses include initiating dialogue, building community capacity, connecting community groups to larger organizations, promoting media advocacy, and promoting group cohesion (Pilisuk et al., 2005). Additional functions include consciousness raising, assistance in policy formation, and political advocacy. In essence, the community health nurse acts as “a motivational catalyst to initiate or precipitate a desire to bring about community-endorsed health reform” (Whitehead, 2003, p. 671). As we saw at the beginning of this chapter, effective community empowerment is the ultimate outcome of community health nursing advocacy.

Case Study

Indigent Health Care

You have been given a referral to visit Mrs. Esparza, who lost her baby after a premature delivery. The address you have been given is located in a poor neighborhood that houses a large number of migrant workers. When you arrive at the home, you discover that it is a two-bedroom apartment occupied by three couples and their five children. Both Mrs. Esparza and her husband are present when you arrive, and both are obviously grieving the loss of their third child. In talking with them, you discover that Mrs. Esparza did not receive any prenatal care and was admitted to the delivery unit of the local hospital after going to the emergency room when she experienced heavy contractions in the 29th week of her pregnancy. Mr. Esparza becomes angry when you ask about prenatal care, shouting that they tried to get an appointment at the health department’s prenatal clinic but were told there was a 2-month wait for new appointments. At that time Mrs. Esparza was in the 5th month of her pregnancy. In tears, he informs you that they did not have the money to see a private doctor. Even though most of the migrant workers are in the United States legally, they are not eligible for any financial assistance. Your state does not provide Medicaid pregnancy coverage for nonresident women. Mrs. Esparza reminds her husband that they are not alone in their suffering. When you inquire further into her comment, she tells you that seven other women in the apartment complex have lost babies at some point in their pregnancies in the last 2 years. You comfort the family as best you can, make arrangements for Mrs. Esparza to receive a postpartum examination at the health department, and refer the three families to the immunization clinic because all of the children in the home are behind on their immunizations. You
explain that both postpartum services and immunizations are free to those who do not have money to pay for them, even for nonresidents.

When you return to the office, fellow community health nurses describe similar visits to families in the area. In checking county vital statistics, you note that the census track where the Esparzas live and two adjacent areas that house large migrant populations have a fetal death rate three times that of the rest of the county.

1. How would you begin to empower the migrant worker community to address the issue of lack of access to prenatal care?
2. What assets might you look for within the migrant community to address the issue?
3. What allies might you find in the nonmigrant community to assist you?
4. How can you motivate participation by community members in the initiative?

Test Your Understanding

1. What is the relationship of community empowerment to similar concepts such as community organization, community building, community competence, and community capacity? (pp. 298–299)

2. What are the levels at which community empowerment occurs? (p. 300)

3. What are the similarities and differences among the community empowerment models discussed in the chapter? Select one of the models discussed and describe how it might be used to foster community empowerment in your own community. (pp. 300–303)

4. What are the elements in the process of organizing for community empowerment? Give an example of each element as it might apply to your own community. (pp. 303–309)

5. What criteria might you use to evaluate the effectiveness of community empowerment in your community? (pp. 311–312)

6. What is the role of the community health nurse in community empowerment? (p. 312)

References


