Community Participation: Lip Service?

Linda M. Sawyer, MS, RNC

Community participation is the cornerstone of primary health care, as defined by the World Health Organization. This article explores the concept of community participation and discusses the barriers and constraints to participation, as well as its implementation and health policy implications.

The participation and involvement of people in health care is an established part of the rhetoric of international health promoted through the World Health Organization (WHO) and the United Nations Children’s Emergency Fund (UNICEF). At the 1978 Alma-Ata Conference, sponsored by WHO and UNICEF, the World Assembly declared the goal “Health for All by the Year 2000.” This goal called for radical health improvements, and primary health care (PHC) was the strategy outlined to achieve it. The Declaration of Alma-Ata asserted that not only is health a fundamental human right, but that people, both individually and collectively, have the right and the duty to participate in their health care. Internationally, the nursing profession has embraced the concept of community participation (CP) as an integral part of the strategy to improve the health of the world’s peoples. It is important for nurses to understand the ramifications of this concept and what it means for nursing practice. PHC and CP are not limited to community health nursing, but are essential underpinnings for nursing practice in all settings.

The community has long been identified as the focus of community health nursing practice. A number of authors have described the concept of “community-as-client.” Ideally, community health nurses work in partnership with the community and involve the community in decision making. Goeppinger and Shuster state that nurses in the past have been active in the implementation of programs and have intervened on the community’s behalf, but not always in partnership with the community. These authors assert that the meaning of partnership is not fully understood or accepted by health care professionals and that the passive compliance of others is more frequently sought. Nurses who practice in other settings and specialties do not often practice with a community-oriented perspective.

Primary health care and partnerships between consumers and providers are emphasized in Nursing’s Agenda For Health Care Reform. In this Agenda, the 70 nursing organizations to date assert that the current health care system has lost touch with the communities it is supposed to serve. According to the preamble to the Code For Nurses With Interpretive Statements, the goal of nursing actions is to support the client’s responsibility for his or her own health and to support the client’s self-determination to the extent possible. Clients are defined as individuals, families, groups, and communities. Watts has stated that the concept of community involvement and the values and purposes of nursing reflect and are congruent with the substantive meaning of democracy.

Internationally, the nursing profession has embraced the concept of CP as an integral part of the strategy to improve the health of the world’s peoples.

Central to nursing’s values is respect for persons and the belief that clients have rights, autonomy, and freedom to choose. Nursing espouses the belief that the client and the nurse are equal participants in the process of promot-
ing, seeking, and maintaining health. Despite the congruence between CP and nursing beliefs, however, many nurses continue to focus only on individuals and to view health and interventions from a microscopic perspective. Nurses attempt to alter the individual client’s attitudes toward health, rather than address the socioeconomic or societal determinants of health. Community health nurses identify the community as being the client, but frequently they provide care within a health care system that does not support the full participation of the community.

The purposes of this article are to define the concept of CP in PHC, demonstrate its congruence with nursing, and discuss the barriers and constraints to the implementation of this concept in practice. Included are examples of nursing’s successful implementation of CP and implications for health policy.

HISTORY
Although PHC and CP emerged as major international strategies to improve the health of the world in 1978, community participation or involvement in health care has been discussed in the literature since the mid-1960s. Foster has asserted that PHC evolved from community development in the 1950s. The roots of the community development movement reach back as far as the second half of the 19th century, with the cooperative movements in the United Kingdom and Scandinavian countries. In 1916 the U.S. Agricultural Extension Service was formed to teach rural farm families about improved farming and housekeeping methods. This service and many other social welfare programs in the United States in the first half of this century, including public health nursing, coalesced to create a movement, defined in 1948 as community development. Community development was designed to promote better living for the whole community with the active participation of the community and, when possible, on its initiative. Stone said that this early period (1940-50) was an optimistic era, during which it was assumed that problems could be easily overcome with the introduction of Western knowledge and technology. Foster has called this the “silver platter” model of development because knowledge and technology from the West was handed to other countries on “a silver platter” as the solution to all problems. The culture of the people in a country was viewed as simply an obstacle to be overcome.

In 1971 WHO and UNICEF commissioned a study to describe and analyze successful attempts to adapt health care to the needs and resources of developing countries. Stone said that there was increasing interest in the needs and concerns of the poor in developing countries. Culture was viewed as a potential resource for development, rather than as an obstacle. Out of this study PHC was defined and presented to the World Assembly for its adoption in 1978. CP is considered the cornerstone of PHC. This concept, influenced by British poor laws from the 16th century, is embedded in the history and culture of North America, with their stress on family responsibility, self-reliance, and self-care.

DEFINITION
“Community participation” is often used synonymously with “community involvement.” Some authors, according to Meleis, prefer the latter term because it implies greater activity. Meleis prefers to combine the definitions of these terms and uses them synonymously to articulate the concept of “participation/involvement.” Several components of and approaches to CP have led to the current definitions. These components and approaches are discussed in “Primary Health Care and Primary Care: A Confusion of Philosophies,” elsewhere in this issue. In summary, however, CP is ideally defined as an active process in which the community identifies its needs and works in partnership with health professionals to meet its needs for improved health.

BARRIERS AND CONSTRAINTS TO PARTICIPATION
Barriers and constraints to CP are fundamentally related to issues of resources, power, and control. The belief in participation is inherent in democracy where, ideally, all people have rights, autonomy, and freedom to choose. Even in democracy, however, some people may have more power to make decisions and more resources to facilitate participation. Thus, for example, communities may have their options for resources and participation controlled by the government or by funding agencies.

Luxury or Necessity?
Meleis has asked whether community participation is a luxury or a necessity. Only nominal participation is ensured if people perceive that their participation is coerced or imposed on them by health professionals or leaders. There is no assurance that actual needs or goals will be identified or met. If participation is a luxury, does this imply a responsibility on the part of the health professionals to motivate and sustain the participation? In either case, participation may mean an additional burden to vulnerable populations or may be an excuse for health professionals’ lack of commitment to delivering health services. Meleis cautions that there is a fine line between invited community participation and health professionals demanding participation. Perhaps one of the first steps in community participation should be a
dialogue between community members and health professionals about the level of participation that the community values and what the role of the health professional will be for that community.

**Health Professionals**
Health professionals often hold positions of expert power in society. According to Rifkin,15 health professionals will have to give up their dominant position in health care to gain improved health status for their clients. Instead, they will need to become resources for the community. The WHO16 has said that community involvement calls for a relationship with clients in which power is shared and clients are active subjects: “Clients must be seen, not as people who are acted upon, passive recipients of the diagnosis and treatment dispensed by the health professional, but as active partners in the matter of curing disease and promoting health.”

Rifkin17 has defined the role of the professional in four approaches to CP: medical, health planning, community development, and self-care. In the medical approach, the professional chooses a group that will use its influence to support professionally defined activities. In the health-planning approach, the professional is the team leader, consults with community leaders, and cooperates with the community to tap resources, define appropriate services, and improve utilization. In the community-development approach, professionals are viewed as a resource and decisions rest with the community. In the self-care approach, the role of the professional is peripheral and the community is expected to meet health needs that the professional is unwilling or unable to meet. Only the community-development approach requires the redistribution of power. According to Rifkin,15 case studies suggest that any program that addresses the issue of community participation must realize that it is also addressing the issue of power.

Community involvement may threaten professionals because it requires the sharing of their sources of power—knowledge and skills. Participation must be resourced with power, knowledge, and skills; otherwise, it will be tokenism. Professionalism has been defined by Biklen18 as the marshalling of exclusive control of the helping process by making it into a discipline, thereby creating and reinforcing social hierarchies that elevate helpers and create dependency in the helped. Some authors assert that there must be de- or re-professionalization in health for true CP to occur.19

**Who Participates?**
Another problem is the assumption that communities are homogeneous entities. Communities have subgroups, and leaders may only represent a segment of the community; indeed, the most vocal community members, and those who volunteer, may be the least representative of the community. In some communities, groups may live in oppressive circumstances that prevent them from participating. For example, women, children, and minori

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**Approaches to Clients’ Needs**
De la Cuesta20 has identified three approaches to clients’ health care needs. The first is “blaming the victim.” With this approach, external factors that affect health, such as poverty, are ignored. It is the client’s responsibility if she or he is unhealthy. This approach encourages adjustment and conformity, and it unintentionally helps perpetuate inequalities. The second approach is “impeding the client.” With this paternalistic approach, the provider defines and meets the needs. Dependence is fostered, and adjustment and acceptance are key factors. This approach could inadvertently squelch clients’ awareness of, and contribute indirectly to, maintaining disparities. The third approach is “enabling the client”; it fosters independence, empowers the client to have control, and focuses on the client’s needs and the community’s strengths. Health issues are addressed through collective costs in providing health care or as a way to decrease the workload for health care professionals. Individuals in a community may see participation as a way to control resources or to further their own self-interest.

Altruism and a sense of a larger community good are needed for successful CP. The good of the majority must be carefully balanced against protecting minorities and the vulnerable. It is a difficult task to prioritize limited health care and development resources in an equitable and effective manner. CP requires public dialogue to reach a community consensus on these difficult issues.

**IMPLEMENTATION OF PARTICIPATION**
CP appears to be the more difficult component of PHC to implement. The implementation of CP is affected by how clients’ health care needs are viewed by health professionals, at what point participation occurs, and in what way the nursing role is defined. There is no one well-developed and tested model of CP in the literature.
action, and there is intentional contribution to bring about social change and lessen inequalities.

Implementation of the enabling approach requires not only the commitment of the professional, but also policy and management support. According to Mabila,21 this support is critical because health is created by balancing individual and sociopolitical responsibility. This responsibility is expressed by caring for ourselves and others making decisions about and controlling life’s circumstances, and having assurance that society is aiming for the conditions that allow health attainment.

Levels of Participation
The ideal of participation around the world has been described along a continuum from semi-forced local contributions of money to revolutionary seizing of power. Participation has been difficult to define because it occurs at many levels. Rifkin15 has described five levels of participation. On the first level, people participate in a passive way as recipients of an established program. They may pay a fee or have to attend a clinic. On the second level, people actively participate in supporting the program by contributing land, money, or labor. At the third level, people participate in implementing the program or managing it once it has been conceived and designed by planners, who offer advice, approval, and supervision. At the fourth level, people participate in the monitoring and evaluation of a program. Rifkin says that this level of participation is rare since usually only lip service is given to evaluation by planners. At the fifth level, people participate in the planning of activities. This is the ideal level, but it is rarely achieved. Rifkin recommends that projects specify the level of participation for which they are aiming.

Arnstein22 outlined eight forms of participation that fall into three major groups: nonparticipation, tokenism, and true participation. Nonparticipation includes manipulation and therapy. Informing, consultation and participation fall into the tokenism category. True participation includes partnership, delegated power, and citizen control. The way in which a community participates depends on the socio-economic-political system.23

Role of the Nurse
Nursing has been described as a natural ally and promoter of the goals of PHC.24 As the largest group of health care providers, nurses combine promotive, curative, and advocacy roles into clinical practice. Additionally, nursing has a commitment to social justice and equity. Flynn, Ray, and Selmanoff25 have asserted that nurses are ideally suited to social action, and this commitment has been demonstrated throughout the history of community health nursing. Unfortunately, nurses often do not see themselves as being activists. Political advocacy skills must be developed and used on behalf of communities and in partnership with them.

The role of the nurse in community participation has been described in various ways. The nurse may be an encourager, a partner, a resource, a facilitator, a catalyst, an obstacle, or an obstacle remover. Nurses, as well as other health professionals, may be obstacles by viewing themselves as experts who need to be providers of service, with this view they may be threatened by a perceived loss of power. Labonte26 has said that the first obstacle that impedes the process of empowerment and that health professionals can remove is their need to define health problems for the community. Nurses also have a responsibility to use their professional power as client advocates for the benefit of the community.

We must differentiate between a service, which is something controlled by the provider, and a resource, which is something wielded by the person to whom it is provided.26 Styles27 has said that professions who share their power and information with the people empower themselves in the process. Nurses need to determine the culture of participation that already exists in the community, how the communities are organized, what means exist for participating, and what skills and resources are available in the community.

SUCCESSFUL EXEMPLARS
Programs using CP that have been touted as being successful internationally have common elements. These successful programs are found in less stratified communities that have supportive environments, political will and structure for participation, decentralized administrations and decision making, government support, and a common history of struggle.19

Lassiter28 described nurses in a rural area using the tenets of “citizen participation” to address problems of low-birthweight infants and farmworkers’ exposure to pesticides. In the first instance, nurses identified the issue of low birthweight and involved other health care workers and community residents in identifying relevant factors and in designing strategies for intervention. In the second, community members identified the problem of pesticide application and came to the nurses for assistance. In this instance, the community members and nurses, working together, devised strategies to address the problem posed by pesticides.

Swider and McElmurray29 have described their work with low-income women in two neighborhoods in Chicago. This project used community health workers from the community, working with nurses, and in 14 months the project provided more than 9000
people with health education, referral, screening, and community organizing activities.

Meleis and Lipson discussed the "Mid East S.I.H.A. Project" at the University of California, San Francisco. This project, founded in 1982, focuses on low-income immigrants, especially women, providing health information, cultural and language interpretation, referral services, and health-promotion workshops. Project staff also serve health care providers through in-service classes in cross-cultural issues and coping styles in illness. Both a goal and a strategy in the workshop series was to empower the women and the community. Arab women leaders actively planned and implemented the program in partnership with the project staff. The community members successfully lobbied the mayor's office in San Francisco for funds to conduct a community assessment of Arab Americans and immigrants to identify their health and social service needs.

Flynn et al. described the program at Indiana University that prepares community health nurses for PHC practice at the master's and doctoral levels. Nurses are prepared for social action by using a community-development approach. CP is the basis for the three semesters of community experience. There is a focus on health policy in the doctoral program. Both programs are aimed at improving the health of the community. Recommendations for the development of a nursing education program to prepare community health nursing leaders for social action in other universities are outlined by the authors.

Stewart has outlined a conceptual framework for nursing education that would resocialize nurses to change from provider to partner. The author asserted that there is an inherent conflict between self-help and professional help. This conflict may be prevented by a resocialization process that is based on the premise of shared power. Nursing students collaborate with and share the helper role and partner role with focal persons and their support network members. This model of nursing education is based on social-support theories and interpreted under the four concepts of the nursing metaparadigm: environment, health, focal persons, and nursing.

Community participation is also relevant for nurses in institutional settings. Morrison described the development of the first hospital unit in the country dedicated to persons with AIDS, at San Francisco General Hospital. The planning, implementation, and ongoing evaluation of this unit was done with the participation of patients, staff, management, community agencies, and community members. This unit has demonstrated that planned, organized, and coordinated programs are cost-effective, have a low staff turnover rate, and can reduce the length of the hospital stay. Patient-centered care, education, and discharge planning are key to success. Morrison has said that nurses must be advocates for patients and empower them to have control over their care to the extent that they wish to have control.

HEALTH POLICY IMPLICATIONS
Policy makers must support community participation as the basis for health care decision making. Health planning needs to be decentralized and health linked to community development and understood in its environmental context. Economic, political, and environmental factors that are precursors of poor health must be addressed.

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Jones and Meleis have proposed a model of health as empowerment. This model addresses people's right to have resources, strengths, responsibilities, and availability of options. The responsibility for health is shared across individual, contextual, and political arenas. Empowerment links people with resources. If there are inadequate resources, nurses can facilitate access only when they participate in creating the needed resources. Jones and Meleis assert that limited personal and social resources for health are political issues.

Anderson has stated that inadequate resources to assist families in assuming responsibility for care is a major barrier to effective home and self-care management. Since self-care is a deeply embedded expectation in North American societies, nurses must demonstrate the long-term and cost-effective benefits to society of providing adequate resources to support self-care in the community. Nurses need to conduct research in these areas and be politically active to influence health policy.

CONCLUSION
In international health circles, fads come and go quickly. Why is CP still in vogue despite its acknowledged difficulties? According to the WHO, CP affords many advantages for improving health care in the world. CP increases access to health care; provides for greater efficiency, effectiveness, and coordination of services; and leads to equity and self-reliance. Local governments see it as being cost-effective. Planners believe that programs using CP are more successful, and that CP is morally consistent with the principles of equality and self-reliance that form the basis for international aid.

CP is a concept that, although enjoying wide acceptance internationally, appears to be multidimensional and very complex in its implementation. It cannot be viewed as an intervention to improve health care; rather, it is a dynamic process and a philosophic underpinning to the provision of health care. Sustaining CP requires time, energy, constant dialogue, and strategies to develop respect, trust, and common goals. Health professionals can help
create a "culture of participation" so that CP is maintained over time.14 Perhaps it is only over time that we can truly evaluate the impact of CP on health. Nurses must continue to explore this concept and make efforts to develop models of practice that are based on CP. They can start by asking such questions as:

- What is the community? How is it defined?
- Is participation congruent with the community’s culture, values, and beliefs?
- Who is participating? Who is not participating?
- Who identifies needs and makes decisions?
- Who provides support, information, or resources?
- Are the necessary support systems accessible to promote participation (time, childcare, transportation)?
- What level of participation do participants need or want?
- What is the role of the health professional?
- What are the potential consequences for the community or the participants?

If nursing practice is to affect the health of the community, it must be relevant to and an integral part of community life. Nursing has historical role models for this type of practice and must extend it, not only in the community, but in all settings in which nurses practice. Thus, if CP is to be more than lip service, we nurses must reorient our practice to be partners with our clients. 

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LINDA M. SAWYER, MS, RNC, is a doctoral student at the University of California, San Francisco.