

The Community as a Full Partner in Public Health Initiatives

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Public health practitioners have increasingly turned to community-based public health (CBPH) as an important approach to health promotion and disease prevention. A convergence of several trends has contributed to the growing interest in CBPH. First, many health issues of greatest concern, such as chronic diseases, violence, and teen pregnancy, are not easily solved by technological, “magic bullet” fixes provided to individuals. Rather, these issues are deeply embedded in the fabric of communities, and communities must participate in their solutions. Second, the social and community factors that affect health status have gained increased recognition as major forces affecting personal well-being. Third, communities are increasingly mistrustful of governmental and other external “experts” coming to them with preformed agendas of how to “help” them improve local health. CBPH provides a framework to address these trends and an opportunity for public health practitioners to work with communities in a more democratic and egalitarian manner.

Defining CBPH

The essence of the notion of “community” is a group of people who have relationships based on common interests and shared identity. The commonalities that create the sense of community can be geographic, ethnic, religious, political and ideological, or based on gender, sexual identity, or any of the many other mutual interests that bring people together. Community-based public health practice occurs in the context of such communities.

CBPH is also characterized by partnership and close, genuine collaboration between communities and health professionals. Such collaboration does not come easily. A wide gap often separates health professionals from communities, especially urban and minority communities. For example, Gambel (1997) has documented a history of programs tainted

by professional arrogance, opportunism, and racism, which has generated skepticism and mistrust among African-American community members.

To overcome this legacy, public health practitioners and community members must develop trust through partnerships that mature over time. Partnership indicates joint participation in all aspects of project planning and execution, especially decision-making, and falls in the middle of the spectrum of community-professional engagement (Table 1).

Partnerships draw on the complementary assets of professional and community members. Both groups may bring technical skills (e.g., data analysis, policy and program planning, organizational development, fundraising, media advocacy), training expertise (e.g., leadership development), and resources (e.g., staff support, equipment and supplies, liaisons with public officials and agencies). Both may contribute knowledge of the community, experience with community-based initiatives, and links to other community members.

Implications for Public Health Practice

CBPH implies that public health practitioners seek out communities as collaborative partners in their work to improve the health of the public. Seattle Partners for Healthy Communities is an Urban Research Center funded by the Centers for Disease Control and Prevention and sponsored by Public Health – Seattle & King County. It has used the CBPH approach to improve health in low-income and minority communities in central and south Seattle. Seattle Partners has developed principles for community-professional collaboration to guide its work (Table 2).

CBPH is most effectively practiced by a multidisciplinary team with a mix of skills

including community organization, qualitative and quantitative assessment, public health nursing, environmental health and health education, and also content expertise in specific areas.

CBPH is especially suited to address the fundamental “upstream” factors that affect the health of communities, factors that community members often identify as priorities for action. For example, the community board of Seattle Partners has singled out developing strong communities and building social support as two areas for productive collaboration.

Community building as a public health approach has been gaining increasing visibility (Minkler 1997; Kaplan 1999). A set of key components characterizes community building projects:

- “Starting where the people are” by beginning with “felt needs” and community assets. Felt needs are community goals on which community members are willing to work.
- Ensuring cultural competence of the project staff and cultural appropriateness of the program plan.
- Using a broad community assessment process that draws upon qualitative and

quantitative approaches in a continuing effort to define needs and assets as projects are carried out.

- Evaluating process, impact, and empowerment to provide feedback to participants regarding successes and deficiencies of their projects.
- Creating a high level of community participation in the project.
- Strengthening social networks among community members and organizations.
- Increasing community competence. Cottrell (1976) defines a competent community as “one in which the various component parts of the community: (1) are able to collaborate effectively in identifying the problems and needs of the community; (2) can achieve a working consensus on goals and priorities; (3) can agree on ways and means to implement the agreed upon goals; and (4) can collaborate effectively in the required actions.” Empowered communities have the capacity to influence the social determinants of health and thereby improve the health of the community and its members.
- Increasing community empowerment to

Table 1: Spectrum of community-professional engagement

Feature	Professional-Dominant	Negotiated Partnership	Community-Dominant
Assessment/ issue definition	Done by professionals Issue often defined as needs/deficits	Issues defined jointly Issue often viewed in terms of assets/strengths	Done by community
Goals	Narrow, predefined	Broad predefined goals with room for modification and specification	Broad, include community capacity development; may change during the process
Community definition	Population with a health problem	Blend	Existing social/identity networks
Leadership	Professionals and socio-political elites	Community as “senior” partner	Emphasis on grassroots leadership development
Participants	Limited, exclusive, selected by professionals	Joint selection of initial members, open to additions	Open, inclusive, self-selected
Organization	Structured and linear	Blend	Flexible and fluid
Decision-making	Agency/professionals	Joint, but who has “last word” is negotiated	Community decides
Accountability	Hierarchical and political	Blend	Community

improve conditions in marginalized communities. Community empowerment is the product of community competence and leads to successful projects in which participants see the results of their own contributions (Labonte 1994; McKnight 1992, 1995; Wallerstein and Bernstein 1994).

- Increasing social capital — the network of affiliations, information, and reciprocal obligations and expectations that develop among people with common interests, and which may be drawn upon as a resource.

Growing evidence suggests that more developed communities are associated with better health (Kawachi et al. 1997). Public health professionals have contributed to community building through staffing coalitions, assisting with community mobilization, promoting leadership development, and other community organizing activities.

Social support also is associated with improved physical and mental health outcomes. Public health practitioners have a long tradition of developing social support. Public health nurses, health educators, and outreach workers directly provide social support through their contacts with clients. Public health workers also organize support groups (e.g., parenting support groups, exercise groups) or engage community members in peer outreach.

One Approach to Public Health Practice

Many CBPH projects start with a small-scale effort, then expand incrementally. A first step is to identify a community partner. Systematically interviewing local leaders can

reveal issues of concern to each community and whether the community sees value in partnering with public health organizations to address these concerns. Next, community members and technical staff from public health agencies can use mixed qualitative and quantitative methods to jointly perform a community assessment. Then they can develop a strategy to address the issues, and public health and community representatives can work together to implement this strategy.

CBPH is one of several approaches to public health practice. The issue at hand and the context will determine the most appropriate approach. CBPH offers certain benefits. It allows interventions to tap into a major community asset: social capital. It facilitates active participation by community partners, thus leveraging public health resources. It respects democratic values and community autonomy. It may therefore be the approach of choice for addressing social determinants of health and behaviors shaped by social and community forces, for working with populations marginalized by discrimination and poverty, and for reducing economic and ethnic health disparities.

Examples of CBPH

This article can present only a few of the many examples of CBPH. Seattle Partners has worked with community collaborators on numerous projects, including increasing immunization rates among Seattle's Central Area seniors (Krieger et al. 2000), monitoring the impact of welfare reform, promoting academic success and integration into public schools for Somali immigrant families, developing mutually beneficial relationships between seniors and children through a Summer Grandparent program, and promoting positive interethnic relationships through youth leadership development among Seattle Public Housing residents. The following examples summarize several CBPH projects.

The Senior Immunization Project addressed a community concern for low adult immunization rates in central Seattle. A partnership of the Central Area Senior Center, the University of Washington, Public Health – Seattle & King County, Seattle Partners, the Health Care Financing Administration, and the Visiting Nurse Services of the Northwest developed a program to increase influenza and pneumococcal immunization rates. Senior Center members reached out to their peers and encouraged them to receive

Table 2: Community-based public health principles

Community is involved in plans and development from the beginning.
Community partners have real influence on program direction and activities.

Community is involved with:

- selecting program priorities and objectives
- planning program activities
- implementing the program
- evaluating the program

The values, perspectives, contributions, and confidentiality of everyone in the community are respected.

Programs will serve the community by:

- sustaining useful projects
- producing long-term benefit for the community
- developing community capacity (training and jobs)

immunizations. These volunteers tracked the immunization status of participants and addressed attitudinal barriers to vaccination. A randomized, controlled study showed that influenza vaccination rates rose by 117% and pneumococcal vaccination rates by 68% among unimmunized subjects (Krieger et al. 2000).

The Reality Check Project is a community outreach and data-gathering effort to monitor the impact of welfare reform in Washington State (WorkFirst) and to provide information to families about changes in welfare laws and programs. Reality Check is a collaborative effort involving Seattle Partners, the Fremont Public Association, the Washington Welfare Reform Coalition (a statewide coalition of community agencies), Public Health – Seattle & King County, and the University of Washington Schools of Public Health and Community Medicine and Social Work. Volunteers and paid community interviewers (who are current or former welfare recipients) meet with current and former welfare recipients and provide information to families. Advocacy groups working on behalf of welfare recipients used the first report to bring problems with WorkFirst to the attention of the State Legislature. A second report is in progress.

The Interdisciplinary Neighborhood Team Project (INTP) of the Snohomish Health District conducted community mobilization projects using the CBPH approach during 1995–98 (Snohomish Health District 1998). An interdisciplinary team discussed the possibility of collaboration with 33 communities, and projects were developed with 17 of them. Each community identified an issue of concern and received technical support from the INTP. Projects included promotion of the “youth asset” approach to healthy adolescent development through the faith community, organizing residents of senior housing units into mutual support groups, mobilizing residents of public housing around community safety issues, working with teens to improve a drug prevention program, developing a coalition to address lice infestation among schoolchildren, and developing a support network for isolated parents.

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