Community empowerment for health visiting and other public health nursing

Stewart M Piper PhD, MSc, PGDE, RGN
Senior lecturer, Faculty of Health and Social Care, Anglia Ruskin University

Correspondence: stewart.piper@anglia.ac.uk

Abstract
This paper explores the community empowerment aspect of health promotion, where social experience is a key indicator of health, from the perspective of health visiting and other public health nursing. This contemporary model of practice is put into a health promotion context by use of a slightly modified framework and by the inclusion of examples of methods and outcomes of practice that link conceptually with the health assets model and aspects of 'Big Society' thinking.
Community development, social capital and capacity building are discussed as key elements of community empowerment with a 'bottom-up' agenda driven by community members. This concerns micro-population health gain, where the process, the quality of the public health nurse-community relationship, is as important as outcome.

Key words
Health promotion, community empowerment, health visiting, public health nursing

Community Practitioner, 2011; 84(8): 28-31.

No potential competing interests declared.

Introduction

Inequalities in health and their socio-economic determinants are well established in the literature and have been reinforced by the Marmot Review (Marmot, 2010). This comes at a time of UK recession, budget deficit and thus pressure on public sector funding which has potential implications both for the provision of health services and the health of the poorest in society. It also comes at a time of NHS reorganisation, restructuring and GP commissioning, but where there is political will for 'Big Society' and devolution of healthcare control, ownership (Milton, 2010) and decision making to communities. This is accompanied by a commitment in the Department of Health (DH, 2011) health visitor implementation plan to expand the health visitor profession, and calls for health visitors to make an important contribution to 'the new generation of community owned services' (Milton, 2010).

While the difficulty in delivering a service beyond core provision is acknowledged (Hardy et al, 2010) given the above constraints, this paper suggests ways to develop the community empowerment aspects of the health promotion role of health visitors and other public health nurses. It does so by using a model of practice that is consistent with the DH calls for:

- Health visitors 'to develop new ways for providing services as part of the Big Society' (DH, 2011: 13)
- Public health strategy in England to 'help build the Big Society' with a focus on health as a social experience and on the health assets of a community (DH, 2010; 4).

Although awaiting precise definition, for the purpose of this paper 'Big Society' means people coming together to influence and create change in their neighbourhoods and communities to solve problems as they perceive them to enhance life (Stott, 2010) and for social health gain.

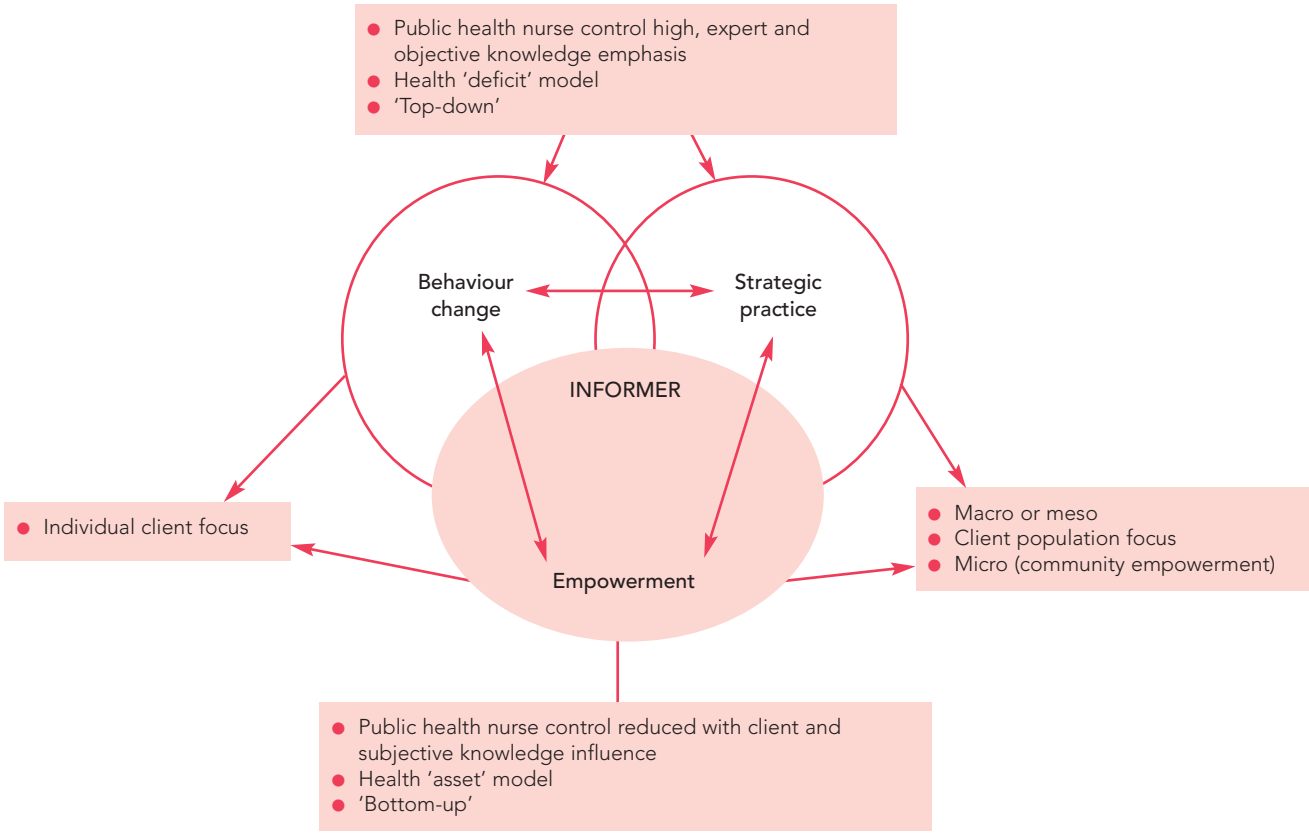
Within public health nursing, community empowerment seeks to facilitate the above and is put into context as a model of practice by the use of a slightly modified version of the author's health promotion framework (Piper, 2009) (see Figure 1) along with work on bottom-up, micro-population interventions. Here, the process of community health gain and the quality of the public health nurse-community relationship is as important as outcome. This is translated into community development, social capital and capacity building, and thus into community empowerment ways to conduct health promotion and concomitant examples of outcomes of intervention.

Health promotion framework

In the earlier work (Piper, 2009), the contention is that health promotion has become central to both health policy and the nurse's role within the UK. It is argued that for nurses to be effective in this role, a 'repertoire' of models is required that can be applied in various settings depending on client group, health need and context. It is also argued that these need to be mapped within a framework specifically developed for nursing rather than importing one from outside the discipline to help conceptualise, integrate and translate the aims, methods and outcomes of health promotion into nursing practice. To this end, the framework (see Figure 1) advances a slightly modified version of the original nursing health promotion framework for public health nursing in order to highlight how community empowerment is distinct and unique. However, it is not mutually exclusive, since elements overlap with the behaviour change and strategic practice models of health promotion. For example, the role of informer underpins all models in the framework because information giving is a core feature of any health promotion intervention.

Public health nursing health promotion can operate from competing and polarised positions of power, with practitioners as expert healthcare professionals using objective, scientifically derived, disease and epidemiologically based health promotion interventions, or as facilitators responding to

Figure 1. Framework of health promotion models (adapted from Piper, 2009)



client driven and subjective appraisal of need. As can also be seen, health visitors and other public health nurses can work with individuals or with client macro- (societal) and micro- (group or community) populations for bio-psycho-social health outcomes. The addition of this client focus dimension generates the three models of health promotion in the framework.

The behaviour change and strategic practice models within the framework converge in so far as they both represent public health nurse-led and thus 'top-down' health promotion interventions, but differ in their individual or client population focus. The former represents a traditional health promotion agenda emphasising client health 'deficits', 'risk factors' and the need for individual health-related behaviour change. In contrast, strategic health promotion is what Tones and Tilford (2001) refer to as 'meso', as it is indirect intervention for health gain via managerial and organisational structures, policies and processes at an institutional or settings level. It can involve working with other disciplines and agencies – an example of this would be school nurses working with teaching staff to develop a 'health promoting school'. Intervention would take a 'whole school' approach and focus on indicators such as a healthy school culture and environment including:

- The quality of the relationships between pupils, pupils and teachers and teachers and parents
- Health in the curriculum
- Personal, social, health and economic education
- Emotional wellbeing
- Exercise and healthy eating (Dooris and Hunter, 2007).

Similarly, when concerned with individual client outcomes, empowerment converges with behaviour change in relation to client focus, but they are opposed on the power continuum where public health nurse control is reduced and client control is increased. Conversely, community empowerment converges with strategic practice when the focus of intervention is at a population level, but here the power base shifts toward the community. Thus, the synthesised framework elucidates the distinctions and commonalities between various models of health promotion with the community element of health visitor and other public health nurse empowerment deriving from a subjective, lay knowledge base with a micro-population and health 'assets' focus (IDeA, 2010).

Community empowerment

In the Ottawa Charter (WHO, 1986), community empowerment is central to health promotion. Laverack and Wallerstein (2001) contend that it is concerned with activism for socio-political change, emancipation and the development of community power. It is a process of local action and organisation by members of a community to improve social health and quality of life (Laverack and Wallerstein, 2001) by developing social networks, connectedness and social justice (Piper, 2009).

Community development

As far back as 1969, Arnstein highlighted the importance of community participation, but warned that it is meaningless if inequalities in power are not addressed and constructed a graded ladder of community empowerment (Arnstein, 1969). This has been modified for nursing by the author (Piper, 2009). It is important to separate the rhetoric of community participation, consultation and devolution of power reflecting a professionally determined health 'deficits' agenda, associated medical model values and compliant community behaviour from genuine public health nurse-community engagement and community development.

Community development involves the community in 'health needs assessment' (DH, 2001: 13), the identification of both local health priorities and health 'assets' (IDeA, 2010) such as 'lay' worker projects (DH, 2001: 13). It is an inclusive process that involves working from the perspective of the community (Dinham, 2005) by capturing shared lay perceptions and cultivating mutual help and support among its members. It is based on a principle of the public health nurse working in partnership and negotiating with community members to build on existing capacity, skills and assets, and the extent of community empowerment depends on how much professional power is relinquished and how much community power exercised (RCN, 2002).

For Webster (1989), the key elements of community development are:

- Facilitating the establishment of community or neighbourhood groups that both provide support to members and influence local health policy, service planning, development and delivery
- Helping community members or groups find places to meet and ways to fund community activities, projects and training.

In other words, much of this process is about capacity building to help community groups and organisations develop the ability to both construct an agenda for change and initiate and manage that change (Handsley, 2007a). It is concerned with building up social capital in the form of community connectedness, participation and trust (Kawachi et al, 1997) through meaningful social networks and relationships. In so doing, it provides a buffer to – and helps with the management of – stress and life pressures, and the development of tolerance, empathy and self-esteem (Cooper et al, 1999; Putnam, 2000).

Pragmatic strategies for health visitors and other public health nurses

For health visitors and other public health nurses to help achieve community empowerment, practice will need to focus on developing what Putnam (2000) refers to as 'bonding'. This involves reinforcing family and close, enduring social and neighbourhood relationships and bridging. These relationships should be based on shared interests and commitments that go beyond local neighbourhoods. This requires:

- An understanding of the social and cultural dynamics of communities (RCN, 2002; Handsley, 2007b)
- Listening to and being prepared to challenge views and perceived needs
- Fostering a culture of collaboration and action in response to these while using accessible language
- Ensuring that any credit or recognition for the success of projects goes to community members (Hawe et al, 1998).

It involves developing relationships with local and national elected representatives, local government officials, community leaders, local groups, health and social care managers and voluntary organisations (RCN, 2002), and mediating between these where there are competing agendas. The process might be helped by mapping community relationships to assist with the analysis of social networks (Public Services Trust, 2010).

The emphasis of this model of health promotion on social relations as a key determinant of health means that GP and NHS service commissioners and managers will need to embrace an approach that will allow public health nurses to shift practice away from individual and disease focused, detached, medical model interventions and adopt a 'low social distance' (Beattie, 1991: 185) way of working, engaging with practical, day-to-day and social community concerns and needs.

The Public Services Trust (2010) argues for power and processes such as service commissioning to be decentralised, with communities actively engaged in shaping local priorities for outcomes with a social value. Piper (2009) cites examples from Watkins and Wilson (1997) of the sort of projects that have a social value and help build social capital, and which public health nurses might facilitate. These include co-operatives for access to fresh fruit and vegetables, crèche facilities, a community café, community newspaper and both support and tenants groups (Piper, 2009). As key members of the public health nursing team, health visitors and school nurses might also work with support groups looking for ways to improve play areas for children, those concerned about dog fouling in public spaces or inadequate street lighting and thus child and family safety.

Challenges

Opportunities for community empowerment will clearly be challenged by a financially tight, target driven, disease focused and medical evidence-based NHS culture. In the reorganised health economy, it will require GPs, commissioners and service managers to support and accept the long-term nature and funding of community empowerment projects, and concomitant budgetary and staff training implications (Watkins, 1997), as well as accepting social capital projects that have a contested evidence base. The argument of Muntainer et al (2000) also needs to be considered – that it is the 'Third Way' politics of reduced government intervention and devolution of responsibility to communities to resolve social issues, including those that are more usually the domain of the state. At the same time, it is important not to allow attention to be diverted away from important determinants of health, such as adequate welfare provision and unemployment.

In addition, Dinham (2005) contends that any successful empowerment outcomes are likely to benefit individuals rather than the community. Members of a community may well not share perceptions about health needs or feel connected (Laverack, 2005) and prominence is being given to these ways of working at a time when civic participation is in decline (Putnam, 2000), thus undermining the bedrock of social capital (Cooper et al, 1999). Civic participation is the victim of a world more concerned with personal development, personal agendas, possessions and a media-, TV- and internet-driven culture (Putnam, 2000) that has changed modes of social interaction.

Conclusion

This paper has discussed community empowerment health promotion for health visitors and other public health nurses that is consistent with the developing public health agenda and 'Big Society'. It has been emphasised that this model of practice is concerned with process as much as outcome. In other words, it concerns the use of enabling strategies for community development, social capital and developing capacity building on community assets and a subjective agenda.

The practice model is thus about the nature and quality of the relationship between public health nurses and the community, and the relationships between community members, for social health gain rather than top-down, objective and professionally-led disease prevention interventions and associated health-related behaviour of individual clients.

Potential strategic commissioning and financial constraints have been acknowledged along with ideological tensions and structural issues, but the political will to develop and harness a community agenda should similarly not be forgotten. Finally, it is important to add that any intervention of this nature must adhere to the DH (2001)

principles of community development practice and NMC code of professional practice (NMC, 2008).

Further information

For a more detailed exposition of community empowerment as a model of health promotion as discussed in this paper, see chapter 8 of the author's earlier work (Piper, 2009).

KEY POINTS

- Health promotion is central to health visiting and other public health nursing
- Inclusive framework of a repertoire of models contextualises health promotion practice
- Community empowerment is an important model within the framework for public health nursing health promotion interventions
- The community empowerment model is process based and concerned with social action interventions, indicators of practice and practice evaluation
- Community development, social capital and capacity building are key to social action

References

Arnstein SR. (1969) A ladder of citizen participation. *AIP Journal* **July**: 216-24.

Beattie A. (1991) Knowledge and control in health promotion: a test case for social policy. In: Gabe J, Calnan M, Bury M (Eds.). *The sociology of the health service*. London: Routledge.

Cahn ES. (1997) The co-production imperative. *Social Policy* **27(3)**: 62-7.

Cooper H, Arber S, Fee L et al. (1999) *The influence of social support and social capital on health: a review and analysis of British data*. London: Health Education Authority.

Department of Health (DH). (2001) *The health visitor and school nurse development programme: health visitor practice development resource pack*. London: DH.

DH. (2007a) *Facing the future: a review of the role of health visitors*. London: DH.

DH. (2007b) *The government response to facing the future: a review of the role of health visitors*. London: DH.

DH. (2010) *Health lives, healthy people: our strategy for public health in England*. Norwich: TSO.

DH. (2011) *Health visitor implementation plan 2011-15: a call to action, February 2011*. London: DH.

Dinham A. (2005) Empowered or over-powered? The real experience of local participation in the UK's New Deal for Communities. *Community Dev J* **40(3)**: 301-12.

Dooris M, Hunter DJ. (2007) Organisations and settings for promoting public health. In: Lloyd CE, Handsley S, Douglas J et al (Eds.). *Policy and practice in promoting public health*. London: Sage.

Handsley S. (2007a) Part V. Promoting health at a local level. Introduction. In: Douglas J, Earle S, Handsley S et al. *A reader in promoting public health*. London: Sage.

Handsley S. (2007b) The potential for promoting health at a local level: community strategies and health improvement. In: Lloyd CE, Handsley S, Douglas J et al (Eds.). *Policy and practice in promoting public health*. London: Sage.

Hardy S, Lowe A, Unadkat A. (2010) Mini-MEND: an obesity prevention initiative in a children's centre. *Community Practitioner* **83(6)**: 26-29.

Hawe P, King L, Noort M et al. (1998) Working invisibly: health workers talk about capacity building in health promotion. *Health Promot Int* **3(4)**: 285-95.

IDeA. (2010) *A glass half-full: how an asset approach can improve community health and well-being*. See: www.idea.gov.uk/idk/aio/18410498 (accessed 6 July 2011).

Kawachi I, Kennedy BP, Lochner K et al. (1997) Social capital, income inequality and mortality. *Am J Public Health* **87(9)**: 1491-8.

Laverack G, Wallerstein N. (2001) Measuring community empowerment: a fresh look at organizational domains. *Health Promot Int* **16(2)**: 179-85.

Laverack G. (2005) *Public health: power, empowerment and professional practice*. Basingstoke: Palgrave MacMillan.

Marmot M. (2010) *Fair society, healthy lives: the Marmot Review*. London: Marmot Review.

Milton A. (2010) Nurses can adapt to new models of care. *Nurs Standard* **24(51)**: 12-4.

Muntainer C, Lynch J, Smith GD. (2000) Social capital and the third way in public health. *Crit Public Health* **10(2)**: 107-23.

NMC. (2008) *The code: standards of conduct, performance and ethics for nurses and midwives*. London: NMC.

Piper SM. (2009) *Health promotion for nurses: theory and practice*. Abingdon: Routledge.

Public Services Trust (2010) *From social security to social productivity*. See: http://clients.squareeye.net/uploads/2020/documents/PST_final_rep.pdf (accessed 6 July 2011).

Putnam RD. (2010) *Bowling alone: the collapse and revival of American community*. London: Simon and Schuster.

RCN. (2002) *The community approach to improving pubic health: community nurses and community development*. London: RCN.

Stott M. (2011) *The Big Society challenge*. Cardiff: Keystone Development Trust.

Watkins S, Wilson E. (1997) Establishing a public health nursing project. *Nurs Standard* **11(36)**: 44-8.

Webster G. (1989) *Community development and health promotion – links between theory and practice (presentation)*. London: Public Health Alliance Symposium 'Health For Who?'

World Health Organization (WHO). (1986) *Ottawa Charter for health promotion*. See: www.who.int/healthpromotion/conferences/previous/ottawa/en (accessed 9 June 2011).

www.commprac.com