

Guide 1: Identifying the goal and objectives of community involvement

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**TOWARDS COMMUNITY INVOLVEMENT:
STRATEGIES FOR HEALTH AND SOCIAL CARE
PROVIDERS**

Guide 1

**Identifying the goal and objectives
of community involvement**

**Nick Emmel
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Introduction

This is the first in a series of guides on community involvement in health published by the Nuffield Institute for Health Portfolio Programme. The aim of this series is to provide health and social care providers with the tools to conceptualise the challenges associated with the implementation of community involvement strategies. This series seeks to aid health and social care providers in agreeing a common starting point and core values when designing and implementing community involvement strategies to reduce inequalities in health.

Community involvement has come to be recognised as an essential part of the planning of health services. Increasingly it is recognised that involving communities is likely to lead to more appropriate and sustainable services through an increased sense of ownership in health promoting activities. Involvement is also important in its own right through strengthening democratic processes and encouraging active citizenship. What is more, there is considerable evidence that communities with self-esteem and self-confidence are able to directly address their health needs and inequalities in health.

In this document we discuss the theoretical aspects of community involvement. Using theory we identify the goal and objectives of community involvement. As well as dealing with theory this discussion is grounded in an overview of government policy and strategy initiatives. It is intended to provide practical leads for health and social care providers developing community involvement strategies.

Despite the considerable impetus to involve communities in health and social care, there is little understanding of the implications of community involvement in practice. The term community involvement is applied loosely to activities which involve lay-people. Defining a programme as community involvement where another term would be more appropriate leads to disillusionment amongst professionals and communities because expectations are not met. Both communities and professionals should have a clear sense of purpose in developing community involvement strategies.

This paper provides a thumbnail sketch of policy for community involvement in the NHS. It provides an overview of the community involvement strategies PCTs are expected to design and implement. An analysis of UK government policy and strategy reveals important reasons for implementing community involvement. These include reducing inequalities in health and addressing social exclusion.

The paper explores the meaning of community and empowerment. The conclusion of this paper is that without clearly defining, describing and understanding a realistic goal and objectives of community involvement, strategies to implement community involvement are likely to frustrate both professionals and lay-people involved in their implementation. Inadequate conceptualisation of community involvement programmes will lead to the failure of these strategies to deliver what is expected of them.

Community involvement and policy

Patient and public involvement is integral to the way in which health services work today. Over the last twenty years or so there has been a gradual and fundamental change in the relationship between health care providers and the public as users and communities. Current policy explicitly directs health providers to work with their local communities to develop shared goals and objectives for improving health and well-being. Patients are no longer the passive recipients of health care.

According to Government policy, the key strategies of patient and public involvement in the new NHS are:

- Partnership between the NHS, patients, and the public.
- The NHS needs to ensure it systematically engages with, and listens to, its local communities.
- These partnerships need to work with all parts of the local community, not just with those groups who have traditionally had links with the NHS, important as these are. Working with the community must include working with the socially excluded, those who have been marginalised or ignored in the past.
- The NHS needs to engage in genuine relationships with people at the local and national level. People must be fully involved in decisions both on their own care and on the way in which services are provided.
- The NHS needs to work with local communities, not just because it is the right thing to do but because effective partnership working will deliver results in the form of:
 - better quality and responsiveness of services;
 - better outcomes of care and better health for the population;
 - reductions in health inequalities;
 - greater ownership of health services; and
 - a better understanding of why and how local services need to change and develop.

(Department of Health 2002b)

Successful community involvement requires time, commitment, and a cultural change within PCTs if it is to succeed. Imaginative and innovative approaches will be necessary if public and patients are to be involved to develop better quality and more appropriate services. This is challenging for health providers who have not been accustomed to working with communities. However, the effort is worthwhile for five reasons:

- 1) services can be provided that meet communities' wants and needs and are appropriate;
- 2) transparency can be promoted and communities provided with a better understanding of the complex decision-making in the NHS and other agencies that contribute to health, thus leading to greater openness, accountability, and confidence;

- 3) groups who are excluded or marginalised can be identified and appropriate plans made to work with these people;
- 4) communities can identify the wider determinants of health and develop plans and frequently implement strategies to address inequalities in health; and
- 5) communities can be empowered and their capacity released to promote self-control and self-confidence to address their health needs through greater confidence in their ability to inform the direction of health and social care services.

Equipped with this overview of the key features that are expected of user and community involvement in the new NHS, it is evident that community involvement is an important way of working. The next section will look at the strategies PCTs are expected to put in place to implement community involvement.

Proposed strategies in PCTs to promote community involvement and health

Community involvement is part of the way in which PCTs will work. Each PCT must have adequate arrangements to develop the skills and capacity among all its staff to involve patients and communities in decision-making. PCTs must develop the capacity among professionals in their organisations and with other agencies, such as local authorities, social services departments, and voluntary organisations, to involve users and communities. PCTs should be responsive to the views, aspirations, and needs of communities and:

- have strategic plans for involving and communicating with patients and the public;
- be able to demonstrate how they have involved patients and provide feedback on the outcome of involvement;
- provide sufficient resources and support to lay-members and professionals who lead on patient and public involvement; and
- take the opportunities presented by the new structures of patient and public involvement, and make use of the Patient's Forums, the Patient Advice and Liaison Services, and the Commission for Patient and Public Involvement in Health to contribute to a change in culture and change ways of involving patients and public (Department of Health 2002b; Department of Health 2002a).

Furthermore, from 2003, PCTs will be responsible for the development of Health Improvement Strategies (HIMPs) with local authorities, the voluntary sector, and local communities. The Department of Health states that:

Primary care trusts will be responsible for assessing the health needs of their local community and preparing plans for health improvement... They will be the lead NHS organisation for partnership working with local authorities and other partners to improve the health of local communities and to deliver wider objectives for social and economic regeneration (Department of Health 2001).

Communities, too, must have the opportunity to release their capacity, express their needs appropriately, and perceive that their time and effort is rewarded through tangible benefits to them in any community involvement partnership.

A clear sense of purpose between partners is one of several features important in any successful collaborative endeavour (Hudson et al. 1999). PCTs, local authorities, voluntary organisations, and communities should have:

- A clear understanding of the goals and objectives of community involvement for all parties;
- Goals and objectives that can be realistically achieved;
- A collaborative starting point expressed as a broad vision rather than as a blueprint (Hudson et al. 1999).

The rest of this paper concentrates on the issues that will need to be considered if this clear sense of purpose is to be achieved in the planning and implementation of community involvement strategies. Any strategy will inevitably flounder without consideration of who communities are, what community involvement entails, and an understanding of the dynamics of community engagement processes and outcomes. Strategies that do not address these issues will leave professionals and communities cynical and dispirited by the experience.

Understanding communities

There is little agreement about what a community is. Yet, if community involvement is to be initiated and sustained it is important to have a clear idea about who is being worked with, and, just as importantly, who is not included.

Figure 1 identifies ways in which health care professionals might identify the characteristics of a community. There are both advantages and disadvantages with this range of definitions.

Figure 1: Definitions of community that may be generated by health professionals (after Jewkes & Murcott 1996)

Definition of community	Examples
geographically	a particular and clearly demarcated population
shared characteristics	young unemployed men, single mothers
communities of interest	ethnic minorities
a numerically defined community	a census aggregate
an administrative area	the population within a PCT
an at risk group	men who smoke and have high cholesterol
a GPs list	a practice's population
tautologically	the community with whom we work

The advantage of the range of definitions in Figure 1 are that they allow health care professionals as 'non-members' of the communities they work with to clearly define the boundaries of particular groups with whom they work. Geographical communities, for instance, are clearly recognisable to the agencies that may work with them. It is easier to plan and account for resource allocation. Similarly, it is possible to measure changes in attitudes, practices, and health status among communities with clearly defined characteristics.

However, definitions generated by non-members of communities may impose a community identity on a group of lay-people which does not correspond with a community identity lay-people themselves recognise. This may frustrate professionals who seek to work with particular groups because they are less likely to receive support and co-operation from these groups who find it difficult to identify with the imposed outsider's definition. Further, the imposition of a label on a particular group of lay-people may hide difference. Excluded groups within a community defined by non-members may not be visible because more articulate and included groups within the community are more likely to become involved.

Disadvantaged groups of the marginalised and powerless are more likely to be missed when definitions of community defined by an outsider observer are applied (Jewkes & Murcott 1996). Communities defined by members may either assert their difference and exclude themselves, or be excluded because they are powerless and do not have an adequate voice to make themselves heard in decision-making.

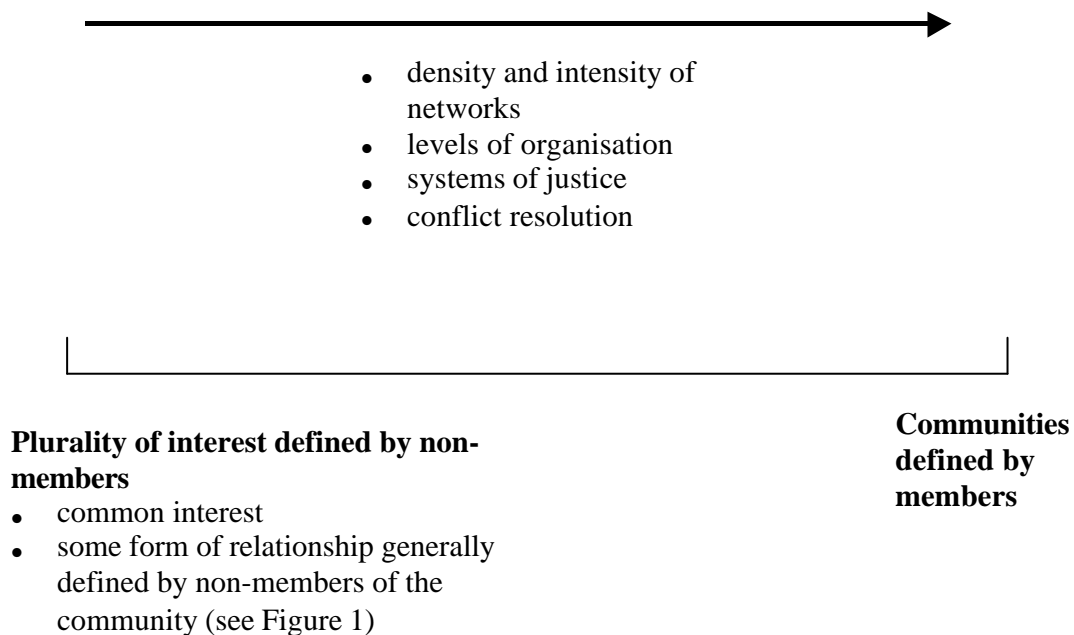
The definitions of community invariably used in community involvement programmes do not adequately address the aims of policy, which talks of genuine involvement of communities, reaching disadvantaged groups, and addressing inequalities in health. A more refined definition of community is needed that captures the relationships people develop between themselves to create communities. Any definition of community must include understanding of people's common sense of identity and the interactions they have with each other.

Defining community

Communities defined by the members of communities are made up of the networks and organisations that bind a group of individuals together. These community generated definitions are quite different from the definition of community that non-members may impose on a particular group. These differences in definition between the characteristics of groups outlined in Figure 1 and community defined by networks and organisation have implications for what a community can do.

Well organised communities can seek and administer justice and resolve conflicts. They can act through the networks and organisations they develop to address issues like anti-social behaviour. Further, the dense networks and organisations a group of lay-people have among themselves, within themselves, and with the communities, voluntary organisations, and service providers with whom they interact, allows communities to make demands on service providers for the services they need to be healthy. Figure 2 emphasises the differences between communities defined by non-members and those defined by members.

Figure 2: A continuum from community defined by non-members to communities defined by members (after Hahn 2002)



Not only does the term community become clearer, but the associated terms strong and weak community now have more meaning. Empowered communities are those with intense and dense networks and high levels of organisation. Such communities are able to demand justice, such as a demand for a particular quality and responsiveness of service. Or are able to address the conflicts that affect the health of community members, such as antisocial behaviour by a minority of people making life difficult for the majority. Lay-people feel they are members of a community, or communities, that can address their day-to-day health needs. Weak communities do not have the networks and organisations to create

communities through which groups of lay-people can voice their health needs. Weak communities are atomised and disempowered.

Driven by the pragmatic need to demonstrate how resources are used and targets achieved (Milewa et al. 1998), professionals, as non-members, define communities that do not necessarily correspond with the networks, organisations, and interactions with service providers that define lay-people's communities. The term community is used where a plurality of common interest (generally between a powerful element in the community and service providers) would be more appropriate.

This loose and inaccurate use of the term community starts to explain why so many community involvement exercises do not succeed in their goal and objectives. There is discord between professionals' and lay-people's views of community. A definition of community must focus on dimensions of empowerment and dis-empowerment and inclusion and exclusion. Lay people understand these dimensions because they are continuously succeeding or failing to negotiate for services to be healthy in their day-to-day lives.

The goal of community involvement

Empowerment has been defined as “a social action process in which people and communities gain mastery and control over their lives” (Wallerstein 1999: 40).

Empowerment conveys a sense of personal psychological control and actual influence in social, political, and economic spheres (Rapoport 1987). Empowerment applies equally to communities and professionals. Empowered communities have mastery over the process of defining their health needs and identifying how these might be addressed. Empowered professionals control the direction of service delivery and apply targets to be achieved without reference to the communities they serve.

Of course this is a dichotomy which simplifies the real world. Professionals will always be influenced by lay-people, although this influence may be indirect. Yet, health care delivery is invariably hierarchical. Professionals hold positions of power to make and implement decisions, while communities are often powerless. As a result policy has sought, on occasions, to redress these power relationships. The Alma Ata Declaration for Primary Health Care, signed by the UK in 1978, for instance, characterises community participation as:

...the **process** by which individuals and families **assume responsibility** for their own health and welfare and for those of the community, and **develop the capacity** to contribute to their and the community's development... This enables them to become **agents of their own development** instead of passive beneficiaries of development aid. They therefore need to realise that they are **not obliged to accept conventional solutions** that are unsuitable but can **improvise and innovate** to find solutions that are suitable... While the community must be willing to learn, the **health system is responsible for explaining and advising**, and for providing clear information about the favourable and adverse consequences of the intervention

being proposed, as well as the relative costs. (WHO & UNICEF 1978: 50—
emphasis added)

The important message from this definition is that it seeks to change the power relationships between professionals and lay-people. Professionals facilitate and guide innovative solutions developed by communities. The ways in which these changes in relationships affect health are dealt with in more detail in the next section of this Guide.

In the light of the earlier discussion, the definition put forward in the Alma Ata Declaration may be criticised for suggesting that communities “develop the capacity to contribute to their and the community’s development”. Communities defined by their dense networks and organisations have potential capacity, which community involvement strategies should seek to release through creating the links that allow these communities to seek justice to address their health needs.

Evidence suggests that empowered communities are healthier communities (Wilkinson 1999). Empowered communities have both a perception that they can control decision-making about aspects of their lives and access to the resources to address their health needs through social support networks. Empowered communities have the power and control to fulfil their material needs. Conversely, disempowered and atomised pluralities of individuals living in poverty perceive they have no decision-making power over their lives and the distribution of resources (Wallerstein 1992). To address inequalities in health it is necessary to address the structural relationships that perpetuate dis-empowerment (Marmot & Wilkinson 2001). Community involvement strategies can contribute to the creation of communities with the power to address inequalities in health.

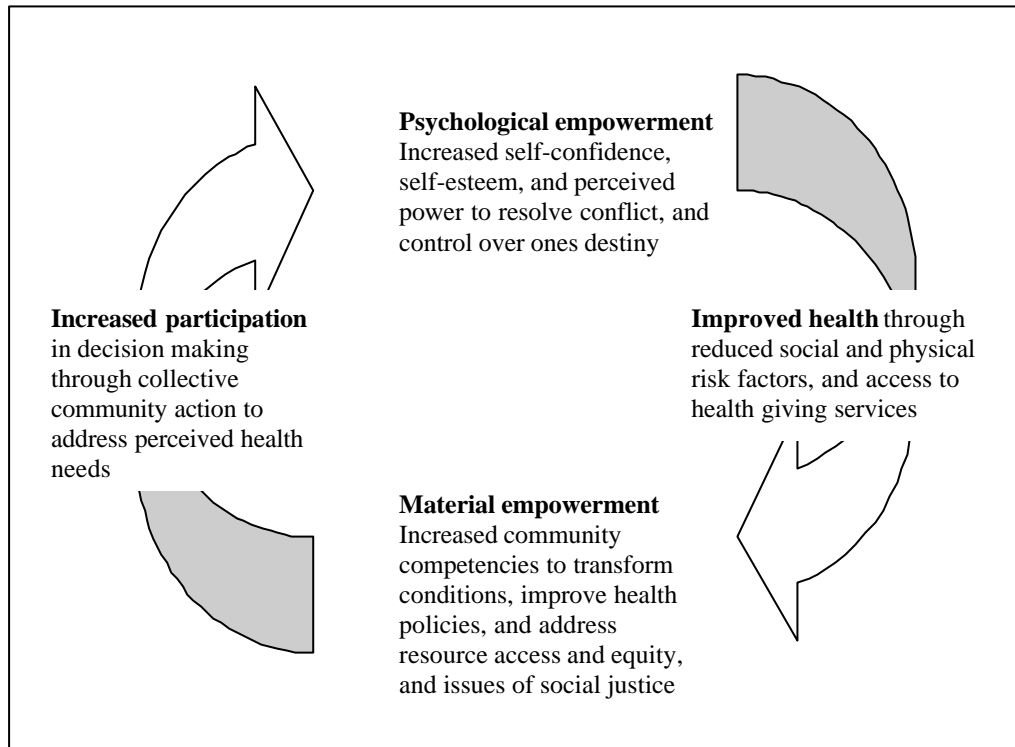
The insights gained from understanding the nature of community help in clarifying the goal of community involvement. As does an understanding of the importance of empowerment in reducing inequalities in health. Thus the goal of community involvement must include reference to:

- addressing the power gradient between lay-people and professionals; and
- strategies to release the potential and capacity of communities.

Empowerment and health

Powerlessness and alienation have been the focus of much consideration within public health. Low self-esteem, lack of perceived control over ones life, and an inability to influence decision-making processes characterised by voicelessness have all been considered important elements in perpetuating inequalities in health. However, much of the debate within public health has focussed on the individual and the psychosocial domain. This has been at the expense of consideration of collective agency to bring about changes in material aspects of peoples’ lives (Connelly & Emmel 2003).

Figure 3: A virtuous cycle of empowerment, health, and community involvement



The discussion in this Guide has focussed on definitions of community which are mediated by people’s ability to develop dense and intense networks of organisation to resolve conflict in their lives and address social justice. There is considerable evidence to suggest that lack of control over ones destiny through living in relative poverty, lacking social support networks and therefore lacking the economic and political power to acquire the services to live a healthier life are important factors in perpetuating or even deepening inequalities in health (see Figure 3) (Marmot & Wilkinson 2001). These material factors are related directly to observations that those who suffer the worst inequalities in health, the poor, have high demands placed on them psychosocially and physically. Not only are the poor invariably excluded from decision-making processes, but exclude themselves through learned helplessness, frequently reinforced by service providers unwilling to listen to them.

It has been observed in this Guide that community involvement strategies may be a means to achieve a particular end, such as the delivery of a service, or as an end in themselves. Projects to achieve a particular end, such as the Runcorn PCG project to address heart disease discussed in Box 1 below, do not involve communities in planning, delivering, or evaluating the service provided. These programmes therefore address only those issues considered by the professionals who have planned the service. Community involvement strategies planned as an end in themselves differ in that they seek to address both the material and the psychosocial powerlessness of communities through empowerment of communities to address their perceived health needs supported by professionals.

Empowerment, as Wallerstein (1992: 1998) observes “becomes the avenue for people to

challenge their internalised powerlessness while also developing real opportunities to gain control in their lives and transform their various settings. Alternatively called participatory self-competence, civic competence, or conscientization...this model includes dimensions of improved self-concept, critical analysis of the world, identification with others as a member of a community, involvement with others in organising for community change, and actual environmental (and) political change.”

This definition of empowerment identifies both the material benefits and psychosocial benefits inherent in community involvement strategies towards reducing inequalities in health. Figure 4 reinforces the links between community involvement, empowerment and health, suggesting a virtuous cycle between the different elements of empowerment and health. These observations lead to a formulation of the objectives of community involvement in health, which are discussed in the next section. They also point to the challenges inherent in developing community involvement strategies, which are the subject of the next Guide in this series.

Towards objectives for community involvement

If the goal of community involvement is to be realised then it is necessary to have a clear understanding of the ways in which community involvement must be planned. Similarly, if the purpose of a programme is to include a plurality of lay-people to achieve a particular and pre-determined target set by professionals, this too must be clearly articulated at the outset. If a detailed vision of the objectives of a programme is not described at the outset then it is likely that both professionals and lay-people will have false-expectations and understanding of what can be achieved.

Figure 4 compares the two poles of the discussion in this paper. First, working with a plurality of lay-people to achieve a particular outcome, such as a predefined target. And second, community involvement as an end in itself, to empower communities.

Figure 4: The features of working with a plurality of people as a means and community involvement to empower communities compared (after Oakley 1989; Rifkin 1996).

Working with a plurality of lay-people	Community involvement
<ul style="list-style-type: none"> ▪ Achieves a set objective (predetermined targets) ▪ May coincide with the perceived needs of lay-people ▪ A means of improving efficiency and service delivery ▪ Involvement in community development as a 'management technique' ▪ Static, passive and ultimately controlled and 'top-down' ▪ Temporary (rapid mobilisation, direct involvement in specific tasks and abandonment of involvement when the target is achieved) ▪ Does not lead to direct control of resources 	<ul style="list-style-type: none"> ▪ Involvement as an end in itself, a process in which confidence and solidarity are built up in the community ▪ Dynamic, unquantifiable, and essentially unpredictable responses to local needs and changing circumstance ▪ Builds organisation and institutions in the community ▪ Lay-people become directly involved in devising solutions to their perceived needs ▪ Dynamic involvement by communities that is 'bottom up' ▪ Long term, seeks to enhance awareness and increase self-confidence. Quantifiable targets or objectives may be set, but these are not seen as the end of the project, rather they are part of an on-going process ▪ Brings about changes in existing institutional arrangements and control of resources by communities and validates the understanding they already have

Work with a plurality of people ensures a continuance of existing relationships, the social status quo, although the delivery of health care may well be increased. The gradients of power between professionals and communities are not addressed in this top-down approach, nor is there an intention to release the potential the capacity of communities. The implications for managers are that the outcomes can be predicted and change measured against baseline data. Resource implications are predictable.

Whereas, if community involvement is planned there is an explicit understanding that the power relationships between professionals and communities will change. Communities will be empowered to identify their health needs and seek solutions to these. The approach is bottom-up, professionals act as facilitators. A cultural change in the way managers plan services is inevitable. Outcomes are not predictable, nor can the resource implications of community involvement strategies be accurately projected (WHO, UNICEF, 1998).

An understanding of the differences between these two approaches will aid both professionals and communities in identifying the objectives of community involvement.

Programmes can fall into the two distinct groups outlined in Figure 4, as the case studies below show.

An example of working with a plurality of lay-people is the Runcorn PCG programme described in Box 1. This is cited in the Social Exclusion Unit's National Strategy Action Plan as an example of good practice (Social Exclusion Unit 2001). The success of this programme in identifying and reducing cardiac morbidity is impressive. The programme is not, however, community involvement, as is suggested in the rather cumbersome phrase "(a) professionally led bottom-up approach to addressing heart disease" (Lyon 2000: 2). It involves a plurality of lay-people, the loosely defined poor of Runcorn, as a means to achieve its results. It is notable that the two goals of community involvement identified at the end of the previous section are not addressed at all.

Box 1: Runcorn PCG and heart disease

Runcorn PCG consists of seven GP practices in the area which is the 19th most deprived Health District out of 354 in the England. "A professionally led bottom-up approach to addressing ischaemic heart disease" (Lyon 2000: 2) has led to a reduction in cardiac events in those aged under 70 years of 16 per cent, which includes a 27 per cent reduction in mortality, and a six per cent reduction in non-fatal heart attacks in the one year since the project started. Lyon (personal communication) reports that this trend is continuing.

The community has been a passive recipient of this project which was initiated by the practices in the area and supported by the Health Authority's clinical governance team. A practice nurse, funded by the Health Authority, has been instrumental in focussing the primary care teams activities on the aggressive treatment of risk factors in the community. In the first year of the project there was a 28 per cent increase in testing for cholesterol levels; a 51 per cent increase in the identification of people who smoke who are at risk from ischaemic heart disease; and increases in the recording of Body Mass Index, uptake of exercise tests and angiogram. There has also been an increase in the number of patients routinely screened for co-morbidity factors including diabetes, stroke, and a 28 per cent increase in patients identified as being hypertensive.

These findings have led to an extension of health promotion activities with those at risk and an increased use of medication. Beta-blockers and anti-platelet therapy are more regularly prescribed. There is a 13 per cent increase in the use of lipid-lowering therapies. Although this approach has led to increased prescribing costs, hospital admissions for non-fatal heart attacks including non Q wave infarcts, and more appropriate use of invasive and non invasive testing, there has been a 45 per cent reduction in deaths, or the equivalent of 68 disability adjusted life years saved.

Whereas Box 2 describes an example of a programme where community involvement is central to the strategies developed. The goal of the programme is to empower communities in decision-making about their health and to release the potential and capacity of communities. It is also notable that this programme is acknowledged by health service

managers for the innovative and creative way in which lay-perspectives have been integrated into decision-making processes.

The other important feature of this programme is that the dynamics of community involvement are accepted. In Figure 4, the word dynamic is prominent in the description of features of community involvement. It is accepted that community involvement is about changing the relationship between service providers and communities. Changes in relationships are not easy. They are time consuming, difficult to measure, and undermine the power of professionals. Pre-determined targets are not necessarily achieved. However, as the case study from Community Action on Health shows, the services developed through this approach are services that start to address the felt needs of communities.

Box 2: Community involvement in the Newcastle upon Tyne (Green 1999).

Community Action on Health was set up in 1995 and works with about 114 000 people in an area of widespread deprivation. It is funded through the Primary Care Group, although is not directly responsible to it. The project gives priority to working with the socially excluded and addressing the needs of minority groups both through its own activities and those of other organisations that work in the area. It has a remit of “involving local people in identifying their health and social care needs and influencing policies and services in order better to meet these needs” (Green, 1999:3).

The project works through wide ranging, interactive consultation with grassroots groups and a systematic action planning process geared to achieving changes in policy and practice in relation to the issues identified by the community. It works with an assumption that local knowledge and experience can actively contribute to the development of appropriate services. A network of local contacts and networks have been established. The project estimates that it consults over 1000 people a year who represent the diversity of the population in this large geographical area. One outcome of this is a model of 'lay representation' on the Primary Care Group that is accountable to the wider community through an inter-linked set of participatory structures and networks.

The project's success is attributed to a flexible and responsive approach to the deployment and building of community development skills in the community. Considerable time and effort are expended in these activities, which are worked out in practice through identifying the levers for change that communities can address. The project is aided by its split from the responsibilities for service delivery.

The project claims some success in integrating the perspectives of different user groups in policy and practice of statutory authorities. Although, an evaluation observed that it is difficult to make judgements about the influence of community and user involvement on policy and practice because “decision-making is so opaque” (Green, 1999:17). Managers in these services consider that the increased dialogue between them and groups in the community is effective. Through this relationship a number of new services have been developed such as Youth Enquires, Family First

and Community Care Development. Evaluators have identified the high value placed on these services by communities (Green, 1999:17).

An evaluation of the project observes that it is making effective progress in facilitating sustained active involvement of local people representing diverse local interests, and in developing a core group to carry forward the projects activities.

Community Action on Health is also valued by health and social care practitioners and managers who feel that it is a good use of health service money. It leads to the improved identification of needs and more appropriate services. As one manager observed,

The health authority makes decisions about priorities and allocation of resources based upon evidence, opinions and views... (Public Health) provides the epidemiological base for needs assessment, and I see the work Community Action on Health does as complementing that in a different way—providing quality information... I see that as a critical part of needs assessment for that particular part of the city, I think it is a very good model. We should be building on this. (Health Authority Manager quoted in Green, 1999:18)

The two case studies (Box 1 and Box 2) and the discussion of the nature of community and empowerment in this paper allow for the objectives of community involvement programmes to be identified. These objectives forms the basis for the discussion in the next Guide in this series. Further, this discussion helps to illuminate reasons why the focus of much of health promotion's activities has been on implementing strategies to empower communities.

The objectives of community involvement¹

1. Health care services must work with communities to address inequalities in health through releasing self-confidence to identify needs and demand justice to address those needs.
2. Communities defined by non-members may not correspond with lay-peoples' understanding of community. Communities are better able than professionals to define the networks and organisations that make up their communities and community boundaries. Service planning and provision should be responsive to definitions of community developed by members.
3. The objectives of community involvement should emphasise the role of communities in planning, implementing, and evaluating health care and other services. Professionals should be responsive to the demands made by communities. This will include evidence of partnership between health services, local authorities, social services, the voluntary

¹ The observations here are based on the discussion in this paper and also draw on work developed as part of Community Action on Health programme in Newcastle upon Tyne (Crowley P 2000).

sector, and communities, and that the health service and other professionals are being called to account by communities.

4. Community involvement strategies need to focus on releasing the capacity within communities. The goal of community involvement is to work with the existing networks and organisations communities create and provide support to direct the capacity communities have. Community involvement strategies will have clear objectives to release the potential community leadership and the confidence of community participants to address their health needs.
5. Community involvement strategies can only be successful if communities recognise that there are tangible benefits to be gained from their involvement. Community involvement strategies must show that it is the community's agenda which is being pursued through evidence of community impact on decision-making and policy. There must be evidence that working in partnership with the community has become the norm across all the local system's way of working (organisational development). Any evaluation of community involvement strategies must identify what the processes have felt like for the participants.
6. Community involvement strategies tend to work with the more articulate and powerful groups within the community. This leaves many members of communities isolated from the process of community involvement. This must be avoided through ensuring that those individuals who represent their community are supported, linked, and accountable to a wide community network.
7. Community involvement strategies must focus on including the excluded in society. The agencies and communities planning, implementing, and evaluating community involvement strategies must support self-identification for socially excluded groups and include these in specific programmes. There must be evidence that minority groups are involved and discrimination is being addressed. This, however, is not enough. Social exclusion is the lack of community. It is not having the networks and organisations to create communities through which groups of lay-people can voice their health needs. Community involvement strategies will have to develop creative and innovative ways of understanding who the socially excluded are and how these groups can develop relationships between themselves and service providers to become involved and active citizens. A focus on social exclusion means considering how power and resources can be redistributed.
8. Part of the goal of community involvement is to address the power gradient between lay-people and professionals. If this goal is to be addressed, planners must accept that fixed time frames for community empowerment are inappropriate.
9. Community involvement activities must be allocated adequate resources, recognising the long term relationships that must be built between professionals and communities.
10. Finally, the purpose of community involvement is to address inequalities in health and work towards a healthier nation.

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