Chapter 6

Community Engagement and Partnership

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Objectives

- Describe how health professionals may promote health equity through community engagement.
- Discuss the importance of partnering with the community.
- Outline how a health professional can engage with a community, including the Community-Oriented Primary Care (COPC) model.
- Discuss how to define a target community.
- Describe techniques of healthy community assessment.
- Explain how health professionals can promote community empowerment.

Health depends, in large part, on the social context within which a person lives. Community, a concept derived from the Latin word *communitas*, meaning common or shared,[1] will be defined in this chapter as a group of people with a shared identity. The community or communities with which an individual identifies define their social context and are potent determinants of health (see Chapter 1).

Engaging with communities to address the broader social and environmental conditions that undermine health is an important role for health professionals. The Centers for Disease Control (CDC) (http://www.cdc.gov/phppo/pce/) defines *community engagement* as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people."[2] Community engagement is a powerful tool for the promotion of health and health equity.

By partnering with a community, learning about its needs and resources, and assisting a community with community-based health interventions, health professionals have the potential to improve the well-being of many more people than they care for individually in clinical settings. For example, health professionals participating in addressing issues like eliminating "food deserts" in low-income communities, or contributing to community-based efforts to prevent violence, can contribute greatly to these endeavors. Ultimately, these efforts improve the health of their patients. One approach is through advocacy work, publicizing and campaigning for policy and political changes to reduce inequities (see Chapter 8). Another approach is to directly engage with members of underserved communities and community-based organizations and partner with them to implement programs at the local level.

This chapter discusses concepts and strategies for health professionals seeking to engage with communities at home and abroad, focusing particularly on community partnership and community assessment. Woven through this chapter is the story of the establishment of the San Diego, California–based Environmental Health Coalition (www.environmentalhealth.org) and its community health worker (or *promotora*) program.

PARTNERING WITH COMMUNITIES

The Environmental Health Coalition (EHC), a grassroots community organization, was founded in San Diego in 1980. It initially worked with union members concerned about occupational health and safety issues and community members concerned about cancer and other environmental illnesses. Founders included industrial workers, environmentalists, health and human service providers, and university professors. Their mission statement includes: "We believe that justice is accomplished by empowered communities acting together to make social change."[3] Health professionals from several southern California universities, including the University of California, San Diego (UCSD), have been involved in many of the projects undertaken by EHC.

The notion of partnership is fundamental to community engagement. Community health interventions by health professionals, whether domestic or international, are much more likely to be effective if they are done in partnership with that community. A *community-based* project is likely to be more successful than a *community-placed* project. A community-placed project is one in which an outside "expert" assumes she or he knows what a community needs, develops an intervention without community input, and then implements it. This can lead to (a) a project that is not valued by the community because it is not addressing one of the community's priorities; (b) methods that are culturally inappropriate; (c) duplication of interventions that have already been tried; and (d) a project that is not sustainable beyond the expert's involvement because it does not have community support. A true community-based project is one that grows from within a community and is led by community members. Community members identify needs and resources, implement an intervention, and sustain the project. Outside experts can participate in this process through effective partnering.

Box 6-1 lists important tasks for health professionals embarking on community engagement. We discuss these tasks in more detail in the following sections.

Box 6-1. Important Tasks When Embarking on Community Engagement

- **Assess** your own resources as a health professional and your short- and long-term interest in becoming partners with the community.
- **Engage** the community by identifying the relevant social networks and leaders and beginning to build relationships.
- **Prioritize** health problems using consensus-building techniques.
- **Develop** strategies to enlist community involvement in the intervention.
- **Evaluate** outcomes, involving the community from the start.

From Wallerstein N, Sheline B. Techniques for developing a community partnership. In: Rhyne R, Bogue R, Kukulka G, et al. (eds). *Community-Oriented Primary Care: Health Care for the 21st Century.* Washington, DC: American Public Health Association, 1998.

COMMUNITY-ORIENTED PRIMARY CARE MODEL

There are many models for community-engaged work. One well-established framework is Community-Oriented Primary Care (COPC), a process through which health issues of a defined population are systematically identified and addressed.[4] Figure 6-1A shows a diagram of the COPC process. The first step is identifying and characterizing a target community. The second step is assessing the needs and resources of that community. The third step is designing and implementing an intervention to address a prioritized need. The fourth step is evaluating the success of the intervention. Involving the community at all stages is an integral part of the COPC model. Community members must be involved as partners, not merely as a source of data. Examples of this partnership include community members who help to define the target community, pose research questions, design survey instruments, gather and/or analyze data, prioritize health issues, design and/or staff interventions, perform evaluations, and write up results. It is ideal if community members have already initiated a community development process along the lines of COPC, and they invite the health professional to join them.

The COPC model is not unlike the process health professionals go through in caring for individual patients. See Figure 6-1B for a diagram of the patient care process. Patient care cannot be successful unless the health professional collaborates with the patient at each step. Patients are not only expected to provide information about their health problems. They are also expected to participate in treatment decisions, changing health behaviors, and monitoring their progress. Similar to engagement at the community level, it is ideal at the individual level if patients are taking the initiative to improve their health and involve a health professional to assist them.

Closely related to COPC is the community-based participatory research (CBPR) model.[5,6] True CBPR is research that embodies core principles of COPC, including community assessment and community engagement.

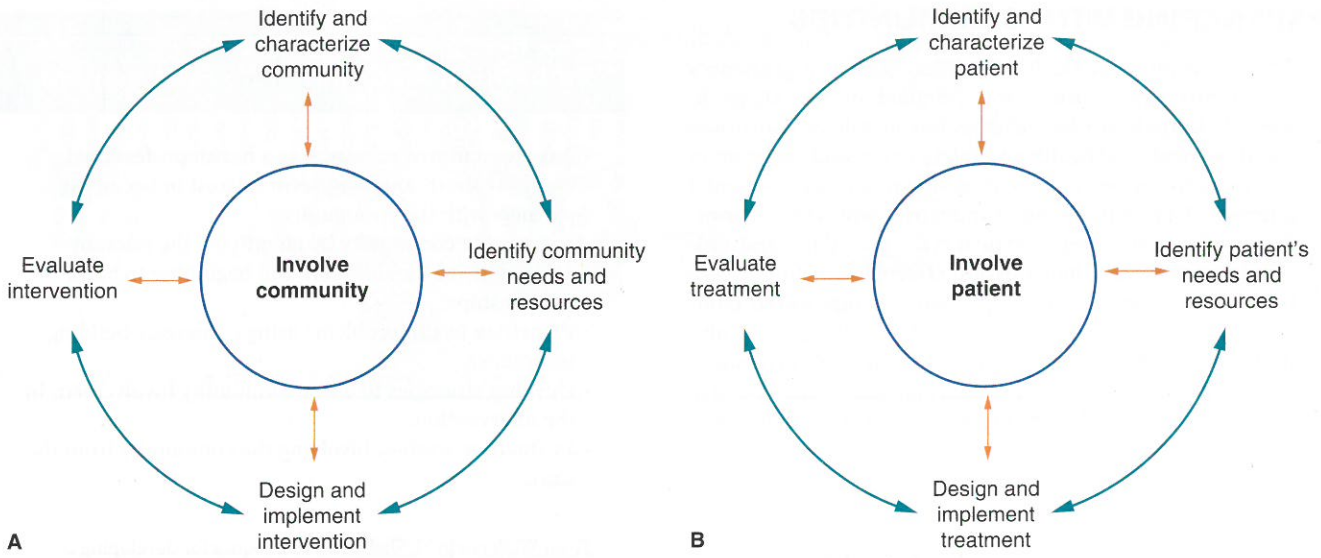

Figure 6-1. Comparison of community-oriented primary care (COPC) and patient care models. **A.** COPC process. (Adapted with permission from Rhyne R, et al. *Community-Oriented Primary Care: Health Care for the 21st Century.* Washington, DC: American Public Health Association, 1998.) **B.** Patient care process.

OVERCOMING THE CULTURAL DIVIDE AND DEVELOPING TRUST

SELF-AWARENESS

Awareness of the cultural divide that often exists between health professionals and underserved communities, and approaching community partnerships with humility, are foundational competencies for successful community engagement. Like all human beings, health professionals have their own biases and cultural norms, and effective community engagement, like effective patient engagement, requires self-awareness. Many health professionals are not members of the communities they serve. This is especially likely to be true for health professionals serving vulnerable populations at home or abroad. Not being a member of the community often means that health professionals face a cultural divide. This divide may include race, ethnicity, language, socioeconomic status, or belief systems, to name a few possible differences. These differences are magnified when working in a foreign country. Just as health professionals strive for cultural competence when delivering health care to individuals, they must work on learning about the realities of community life if they want to engage successfully with a community. Tervalon and Murray-Garcia suggested the term "cultural humility" rather than cultural competence.[7] They described cultural humility as incorporating "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient–physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities."

ACADEMIC AND COMMUNITY PERSPECTIVE

The cultural divide commonly includes the gap between the academic medical perspective and the community perspective.[8] Freeman describes the *academic perspective* as more focused on theory, analysis, and educational value, and the *community perspective* as more focused on practical solutions, service, and action. Because of their different perspectives, academics sometimes behave in ways that are or appear to be disrespectful and generate mistrust in the community. For example, academics performing research in a community may promise to share results with that community; however, the communication of results may never happen. This missed step can represent a betrayal of trust from the community's perspective. Explaining what to expect of an academic approach and integrating elements of a community perspective may improve academic–community partnerships.

Trust tends to develop over time with long-term relationships, but health professionals often come into a community for a relatively short period defined by the duration of a course or a grant-funded project. Repeated experiences like this can leave community members feeling used and mistrustful of other health professionals who try to engage with them. Needs assessments that identify pressing social issues but do not lead directly to a subsequent intervention can be frustrating for community members.

COMMUNITY AND PROFESSIONAL EXPERTISE

Another potential element of the cultural divide between health professional and community is the paternalistic role that health professionals have often played with their patients—a role that may be extended into community work, with poor results. When doing international work, this can be reminiscent of the damaging effects of colonialism. When health professionals assume that they know what would be best for the health of their target community, they may alienate and disempower community members. Conversely, taking a more collaborative approach and heeding the collective wisdom within the community is more likely to build trust and promote community empowerment. Community members know their communities best and usually have considerable wisdom and practical perspectives about solutions to community problems. Both locally and globally, health professionals engaging with community members can ask for them and their communities to recommend solutions. Health professionals should listen when solutions are offered, sincerely consider these possible solutions, and respectfully offer or add their own expertise as health professionals to help the project succeed. This can lead to increased trust as well as increased likelihood of success, as the combination of community expertise and professional expertise often yields the best intervention strategies.

ENGAGING THE COMMUNITY

> Barrio Logan is a San Diego neighborhood with a mix of residences and industry, nestled between Interstate 5 and San Diego Bay's shipyards, 20 miles from the border with Mexico. Most of the residents of San Diego's Barrio Logan neighborhood are Latino, and 33% of families are living in poverty. There are strong community associations, ranging from labor unions to informal social networks of women.

Engaging the community involves two initial steps: defining the community, and gaining entry into the community and developing partnership.

DEFINING A TARGET COMMUNITY

There are several ways to define a targeted community: (a) a geographically defined neighborhood; (b) a group of people working or going to school together; (c) a group of people with some shared sociologic characteristic such as age, language, and a shared history, cause, or identity; or (d) a clinically defined population, such as persons with a particular health problem or patients served by a particular clinic.

The last definition of target communities has limitations. People with a particular health problem or patients of a particular clinic may not feel a shared identity with others in those respective groups, and shared identity is at the heart of any definition of community. The less a community has a sense of group identity, the harder it is to engage with that community in a way that encourages community members to take responsibility for improving overall community well-being. Moreover, if a health professional limits the target community to people with a particular health problem or patients of a particular practice, the health professional may miss the opportunity to reach out to people who have not yet been diagnosed with that problem or who have not yet accessed clinical care. Many opportunities for preventing disease also are missed. This significantly decreases the potential community health and health equity impact of any intervention that is undertaken.

Involving community members in the definition of the target community enhances the likelihood that the target community will have a shared identity and encourages community members to take responsibility for improving overall community well-being. In addition, there are advantages to defining a target community in a way that respects precedents for delineating the relevant population, particularly when those definitions align with existing categories for organizing and reporting population-level data. For example, a geographic community defined along census track lines allows census data to be used more easily. On the other hand, by defining a target community in a way that has been done previously, one has to be careful not to adopt imposed geographic boundaries or demographic group definitions that may not reflect the true degree of social connection and shared identity among the target population.

DEVELOPING TRUSTING PARTNERSHIPS

Once a target community is defined, health professionals must start to build relationships with collaborators in that community. Health professionals without existing relationships in a community must identify potential collaborators to approach, often beginning with key informants who are respected in the community and who may suggest other individuals and groups to approach. Building partnerships with preexisting community-based organizations or official community leaders is valuable; however, it is also essential to make sure that "grassroots" community members are consulted and involved in the project. True community leaders often exist outside of organizations. When that is the case, the health professional will find it difficult to gain the trust of the general community if she or he collaborates only with the governmental leaders. Also, it is important not to rely too much on any one community group or organization. The project can be undermined if that organization loses funding or

leadership, or if internal community politics do not favor the group. On the other hand, some projects bog down because they try to involve too many organizations from the beginning. Sometimes, the best approach is to develop a strong relationship with one organization, demonstrate to the community the value of the partnership, and then add other partners over time as trust is built.

To earn trust when approaching a community for a time-limited engagement, it is important to find out about the community's experiences and current expectations, to be clear and honest about time and programmatic limitations, to plan for mutual benefit, and to be realistic to deliver on promises made. It is helpful to partner with an existing community-based organization that already has and will continue a long-term relationship with the community. The time-limited nature of a grant or project should be discussed with partners in the planning and implementation and careful consideration should be given to sustainability of interventions.

The time of community members must be valued. When health professionals attend meetings for community projects, they often are doing this as part of their paid jobs. Community team members should not be expected to volunteer their time if other team members are not. If community members are expected to attend regular meetings, there should be consideration of reimbursing them for their time or offering another appropriate incentive, such as a grocery store gift card. Childcare and transportation might be provided to facilitate community participation.

Reflection, a key component of the service-learning educational model,[9] should be integrated into the process. Pausing to reflect as a team at each step of a project can strengthen partnerships by improving communication, promoting understanding, and preventing future problems. Reflection can be done verbally and/or in writing. Building on the reflection process, health professionals can help foster an environment in which all partners can share feedback honestly. Community members must feel comfortable sharing their feedback, and health professionals must listen carefully and respond respectfully to that feedback.

Learning how to partner with a community in order to undertake community health interventions is challenging. It takes patience and perseverance to do partnership work well, but the rewards can be tremendous. An international organization, Community-Campus Partnerships for Health, has identified twelve "Principles of Partnership," through an inclusive process involving community and academic partners (see Box 6-2).[10] These may be useful as guidelines for establishing new partnerships or as a checklist to assess existing partnerships. Highlights of these principles include respect, trust, clear communication, and shared power.

Box 6-2. Guiding Principles of an Authentic Partnership

1. Forms to serve a specific purpose and may take on new goals over time.
2. Agrees upon mission, values, goals, measurable outcomes, and processes for accountability.
3. The relationship between partners is characterized by mutual trust, respect, genuineness, and commitment.
4. Builds upon identified strengths and assets, and also works to address needs and increase capacity of all partners.
5. Balances power among partners and enables resources among partners to be shared.
6. Partners make clear and open communication an ongoing priority in the partnership by striving to understand each other's needs and self-interests, and developing a common language.
7. Principles and processes for the partnership are established with the input and agreement of all partners, especially for decision making and conflict resolution.
8. There is feedback among all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.
9. Partners share the benefits of the partnership's accomplishments.
10. Partnerships can dissolve, and when they do, need to plan a process for closure.
11. Partnerships consider the nature of the environment within which they exist as a principle of their design, evaluation, and sustainability.
12. The partnership values multiple kinds of knowledge and life experiences.

From CCPH Board of Directors. Position Statement on Authentic Partnerships. Community-Campus Partnerships for Health, 2013. Available at https://ccph.memberclicks.net/principles-of-partnership.

Common Pitfalls

- Failing to define the target community clearly or appropriately
- Insensitivity caused by lack of awareness of the cultural divide between health professionals and community, often resulting in lack of trust
- Failing to learn about or assess the community
- Focusing only on community needs while overlooking community resources and community-generated solutions
- Failing to partner with the community, or failing to do so effectively

ASSESSING A COMMUNITY: MAKING PRIORITIES AND SETTING GOALS

Pollution and poverty in Bario Logan adversely affect the environment and the community's health. In 1997, a team of community members, EHC staff, and health professionals conducted a health survey that revealed that approximately 20% of Barrio Logan's children were having severe asthma-type symptoms. EHC started working with a group of promotoras (community health workers), local women who are knowledgeable about and trusted by their community. Partnering with EHC, health professionals have provided technical training for the promotoras about a variety of health and environmental issues such as asthma and lead poisoning, increasing the promotoras' health literacy and building their capacity to promote health equity.

Successful community engagement and community health improvement programs require assessment of the community, including describing what resources already exist in the community and what needs are unmet. If this step is skipped or done superficially, the health professional may proceed with incorrect assumptions that can result in inappropriate health interventions, duplication of services, or interventions that are not sustainable. For example, there is often a temptation to start a brand-new program from scratch. It is often better for long-term community development to build on existing community assets than to start completely new programs.

NEEDS-FOCUSED AND CAPACITY-FOCUSED ASSESSMENT

In the book, *Building Communities from the Inside Out*, Kretzmann and McKnight describe two paths to community development: needs-focused and capacity-focused.[11] The traditional needs-focused path focuses solely on problems and needs, rather than including resources and possible solutions. This may have negative results at the community level, including fragmentation of services, funds being directed more to service providers rather than community members, community leaders highlighting problems rather than promoting strengths, outside experts being promoted as the only ones who can solve problems, focus on survival rather than development, and general community hopelessness.

Kretzmann and McKnight promote a resource-centered approach. They highlight identifying and connecting the building blocks of people and institutions as the keys to community development. Examples of these community assets include teens and elders; religious organizations and neighborhood groups; and local businesses, schools, and clinics. When community members identify and interconnect these assets, invest some of their own resources into the process, and take responsibility for setting priorities and finding solutions to fill gaps, the result is likely to be personal empowerment and successful community development.

HEALTHY COMMUNITY ASSESSMENT

Hancock and Minkler promote the idea of a "healthy community assessment" rather than the more traditional "community health assessment."[12] They build on Hancock and Duhl's definition of a healthy community, developed for the World Health Organization (WHO): "A healthy [community] is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."[13] The healthy community assessment is thus a much broader assessment than a review of statistics on demographics, morbidity, mortality, and so on. Ideally, this assessment involves the community as active partners in performing the assessment.

A number of methods can be used to perform a healthy community assessment, and they can be grouped in different ways: primary data versus secondary data, studies versus stories, quantitative versus qualitative, and so on. These methods do not need to be mutually exclusive. In fact, mixed-method approaches, using primary and secondary data, and qualitative and quantitative approaches are ideal. Assessment methods may also be categorized based on the degree of contact with the community[12,14] (see "Core Competency").

No Contact Methods

"No-contact methods" consist of gathering official statistics and preexisting documents, often referred to as secondary data. These are good places to find out about demographics, health access, morbidity, and mortality. An enormous amount of data about many communities can be found online.

Minimal Contact Methods

Geographically defined communities can be assessed through a driving ("windshield") or walking tour. Health professionals might look for health clinics, hospitals, dental clinics, nursing homes, sources of mental health care, and pharmacies. It is also important to observe the people, houses, places of worship, community-based organizations, businesses, schools, parks, potential environmental hazards, police and fire services, and public transport.

Interactive Contact Methods

"Interactive contact methods" hold the potential for community empowerment through opportunities for community

members to be involved and acquire new skills and knowledge. These methods of community assessment can provide valuable primary data but require significant investments of time. Conducting surveys, focus groups, and key informant interviews of community leaders or representative samples of community members are examples of these methods. Conducting focus groups[15-17] and surveys[18,19] is complex, and is beyond the scope of this chapter, but there are many other sources of information on these subjects.

Key informant interviews are a mainstay of interactive contact methods. The first step is determining whom to interview. Anyone who is a member of a community or who works with a community can harbor valuable information about that community and be a key informant. They may be official leaders such as a member of a community advisory board, a local politician, a religious leader, a clinic director, a teacher, the executive director of a community-based organization, a nurse, a community health worker, or a business owner.

Informal "community leaders" are less readily identifiable to an outsider but are often invaluable sources of information and important allies. Informal community leaders are more likely than official leaders to live in the neighborhood, send their children to local schools, share the same socioeconomic status as the rest of the community, be sought out for advice by other community members, and be trusted by the community.

Interviews are particularly useful for learning about the history of the community, the positive aspects about the community, what resources exist, how existing services are perceived, what environmental hazards exist, and what needs are perceived. Key informants, like all people, come with their own biases. It is important to establish the nature and length of their association with the community. The greater number of key informants interviewed, the more well-rounded a view of the community is obtained.

A healthy community assessment is a necessary step for health professionals to take during the community engagement process. The depth of the assessment depends on the time and resources available. It is advisable to use multiple methods to get the fullest possible picture of the community.

INTERVENTION AND EVALUATION

After engaging with a community and learning about its needs and resources via a healthy community assessment, next steps are jointly establishing priorities and goals, developing interventions to achieve those goals, and evaluating processes and outcomes of the interventions. These steps must be taken with full community participation, and building on existing community resources. Combining effective process strategies with scientific evidence and community wisdom about what works and will make an intervention feasible and sustainable can lead to successes worth celebrating. Many different frameworks and methods exist to guide these steps. From aid in setting priorities (http://www.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples-2.pdf) to developing and evaluating projects (http://ctb.ku.edu/en and http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/evaluation.cfm), extensive tools for these steps are widely available (see "Resources").

COMMUNITY EMPOWERMENT

> EHC promotoras advocated at San Diego Port Commission meetings and were ultimately successful in stopping methyl bromide fumigations at a fruit warehouse just a quarter mile from the Barrio Logan elementary school and local homes. Community members participated in rallies, press conferences, candlelight vigils, visits to local politicians, and signing of petitions to achieve their victory. Local artists have woven some of EHC's work into beautiful and powerful community murals as a form of social advocacy.

For a community to become healthier, community members need to lead the process. Health professionals who are partnering with a community on health projects should promote this and not inadvertently undermine it. This is analogous to the way in which health professionals must facilitate patients' taking charge of their own health. Just as the principles of person-centered care are especially important with vulnerable patients, the parallel approach to community work is especially important with vulnerable and underserved communities. It supports those communities in becoming stronger, healthier, and more empowered.

McKnight suggests the following values for health professionals working with communities[20]: (a) respect community wisdom, (b) share health expertise in the form of understandable information that enables the community to solve its own problems, (c) promote the use of system resources for the enhancement of community capacities, and (d) focus on magnifying the gifts, capacities, and assets of individual community members and the community as a whole. In these ways, health professionals can promote empowered communities.

CONCLUSION

Fostering healthy communities and partnering with communities are important roles for health professionals. It takes time, patience, and perseverance to build trust and to make partnership work well. Through community engagement, community assessment, and community partnership, health professionals can expand their reach

beyond those individuals who enter the doors of their clinic and promote health equity through broader community improvement. Using these approaches, health professionals have the opportunity to improve the lives of individuals and the communities in which they live and work.

KEY CONCEPTS

- Engage with the community in some way.
- Use the Community-Oriented Primary Care (COPC) model, involving community members.
- Conduct broad healthy community assessment using multiple methods.
- Build partnerships with community members in all phases of work to produce a community-based project.
- Evaluate your interventions.
- Promote community empowerment whenever possible.
- Understand that partnerships take time to build and develop.

CORE COMPETENCY

Methods for Healthy Community Assessment

1. **No Contact Methods (useful preliminary step)**
   a. Review official statistics (e.g., census data, public health department data, school district data, birth/death records, crime rates)
   b. Review documents (e.g., community newspapers, newsletters, progress reports, bulletin boards)
   c. Review websites
2. **Minimal Contact Observational Methods**
   a. Driving or walking tour
   b. Visits to neighborhood businesses (e.g., a coffee shop, a store, or a nursing home)
   c. Attendance at community meetings (e.g., attend a PTA meeting or a religious service)
3. **Interactive Contact Methods**
   a. Key informant interviews
   b. Small group methods (e.g., focus groups)
   c. Surveys (e.g., door-to-door or other face-to-face interviews)
4. **Participatory Methods**
   Any of the listed methods when done in partnership with community members

Adapted from Hancock T, Minkler M. Community health assessment or healthy community assessment: Whose community? Whose health? Whose assessment? In: Minkler M, ed. *Community Organizing & Community Building for Health and Welfare*, 3rd ed. New Brunswick, NJ: Rutgers University Press, 2012;153–170.

DISCUSSION QUESTIONS

Identify a community with which you would like to work.

1. How would you define that community? What are the advantages and disadvantages of defining the community in this way? Would the community you are defining recognize themselves as a community and/or define community in the same way?
2. At what point in your work with the community would you begin to involve community partners? Why? With whom might you partner? How would you identify and/or decide with whom you will partner?
3. What will be some of the challenges to developing effective community partnerships? How will you overcome those challenges?
4. How will you learn more about the community? What kinds of information are you looking for? What are the best methods of getting the information you need?
5. Give some examples of community-based health interventions that you and your partners might consider implementing in this community. Is there evidence for your intervention? For each example, think of what might be the challenges to implement this model and how would you address the challenges. What would be your first step?

RESOURCES

www.ccph.info

Community Campus Partnerships for Health (CCPH): A nonprofit organization that promotes health through partnerships between communities and higher educational institutions.

http://ctb.ku.edu/en/toolkits

Community Tool Box: Maintained by the University of Kansas, this Web site provides over 7,000 pages of practical guidance on over 300 different topics related to community building.

www.environmentalhealth.org

Environmental Health Coalition: A grassroots organization dedicated to achieving environmental and social justice.

http://naccho.org/toolbox/

National Association of City and County Health Officials has many tools, courses, rubrics available outlining approaches to community engagement

http://www.thecommunityguide.org/index.html

Guide to Community Preventive Services

http://www.rwjf.org/en/how-we-work/rel/tools-and-resources.html

Robert Wood Johnson Foundation

Minkler M, ed. *Community Organizing and Building for Health and Welfare, 3rd ed.* New Brunswick, NJ: Rutgers University Press, 2012.