A Nursing Model of Community Organization for Change
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Abstract  Community health nursing has the potential to reach beyond the individual and create interventions that affect the community as a whole. The Nursing Model of Community Organization for Change presented in this article describes the relationships among the concepts of empowerment, partnership, participation, cultural responsiveness, and community competence within a community organizing context. These concepts are implemented through the use of the Nursing Model of Community Organization for Change, which consists of four phases: assessment/reassessment, planning/design, implementation, and evaluation/dissemination. This nursing model provides a theoretical framework for community health professionals when creating community health interventions in partnership with community members.

Key words: community health nursing, community organizing, nursing model, community competence, community partnership, empowerment, cultural responsiveness.

Community health nursing is developing relationships with and among individual community members and community organizations with the goal of facilitating the empowerment of individuals and the community as an organized whole, thereby increasing community competence. “Community health nursing combines the knowledge and skills of nursing with those of public health science to maintain, protect, and promote the health of specific populations, or aggregates” (Spradley, 1991, p. 83).

Communities are comprised of individuals who share a common goal and are bonded by locale, interdependent social groups, interpersonal relationships, and culture. The culture of the community gives rise to values, norms, beliefs, and a sense of connectedness for its members (Thompson & Kinne, 1990). Communities possess capacity, skills, and assets that when recognized and utilized can serve as a springboard to action toward community change. Through the process of identifying and utilizing resources within the community, the community members become empowered to recognize and understand health-related issues of concern within the community and to mobilize community assets to improve community health (El-Askari et al., 1998).

Community organizing has its roots in social work and grassroots social movements, such as the labor movement and the civil rights movement (Minkler & Wallerstein, 1997). Community organization is “the process of purposefully stimulating conditions for change and mobilizing citizens and communities for health action” (Bracht & Kingsbury, 1990, p. 66). Minkler and Wallerstein describe community organization as “the process by which community groups are helped to identify common problems or goals, mobilize resources, and in other ways, develop and implement strategies for reaching the goals they collectively have set” (p. 241).
THEORETICAL BASIS

The Nursing Model of Community Organization for Change combines the nursing process with community organizing principles (Fig. 1). The theoretical underpinnings of the model are derived from a combination of systems theory, social learning theory, diffusion theory, and social support theory. These theories were chosen because of their emphasis on communities as systems of change, environmental effects on individual learning, information dissemination at the community level, and the importance of social relationships to individual and community health.

Systems theory provides a way of regarding a community as a system composed of various subsystems, such as schools, churches, families, and individual community members. In fact, the community system itself is a subsystem of its various suprasystems, such as the environment. These systems, subsystems, and suprasystems are each surrounded by boundaries, which have varying degrees of permeability. The degree of permeability of these boundaries establishes the norms of interaction between the system, its component subsystems, and the surrounding suprasystems. The boundaries allow for the exchange of information. Feedback loops by which a system receives its own output as input serves to maintain stability or promote change (Sills & Hall, 1977).

Important systems theory concepts include ecology, dynamics, interrelatedness, and holism. Ecology refers to a system that is in an interactive relationship with its geographic and social environment. Dynamics refers to a system and its component subsystems that are constantly adjusting and adapting to changes within the system or to information received as input. Interrelatedness describes how system components are interrelated and how a change in one component will cause change within the entire system. Holism refers to the concept that the system as a whole is greater than the sum of its parts. These system qualities are what make communities as systems responsive to community organizing methods of promoting change (Thompson & Kinne, 1990).

Bandura’s social learning theory addresses the notion that behavior, environment, and person constantly interact. An influence or change in one leads to a change in another. However, merely exposing individuals to new information is insufficient to execute behavioral change. The attitudes and behavior of the community can exert significant influence to facilitate change at the individual level. Social norms or pressures are a critical influence in learning and behavioral change. Utilizing the social learning approach, behavior change can be affected through use of community members as role models, mass media, and existing social networks (Baranowski, Perry, & Parcel, 1997; Lexau, Kingsbury, Lenz, Nelson, & Voehl, 1993).

Diffusion theory defines diffusion as the process by which information, goals, and objectives are communicated through certain channels over time among members of a social system. Information disseminated at the individual level is ineffective in promoting community-wide change. Disseminating program components, goals, and evaluation results to the community involves the use of multiple forms of communication, including formal (e.g., media, town meetings) and informal (e.g., flyers, posters, focus groups) communication channels. The ultimate goal is not merely dissemination of knowledge, but also the adoption and maintenance of healthier practices throughout the community (Oldenburg, Hardcastle, & Kok, 1997).

Social support theory describes how aid and assistance is exchanged through social relationships and interpersonal transactions. “An understanding of the impact of social relationships on health status, health behaviors, and health decision making contributes to the design of effective interventions for preventing the onset or reducing the negative consequences of a wide array of diseases” (Heaney & Israel, 1997, p. 179).

There are four broad types of supportive behavior or acts included in this theory. They are emotional support

![Figure 1. A Nursing Model of Community Organization for Change.](image-url)
which focuses on gaining skills and increasing self-esteem, the distinction between empowerment of the individual, and illness. It is important to make the community members as well as the empowerment of the necessary to facilitate the empowerment of the individual and economic power to affect change in a complex and often forbidding society. Powerlessness has been found to be a strong risk factor for illness and disease (El-Askari et al., 1998; Wallerstein, 1992). It is possible to have a community full of empowered individuals and still not have an empowered community. Only by working as a social unit will the community be able to achieve the broad changes needed to address major determinants of health such as socioeconomic conditions, physical environment, and access to quality health care (Washington State Department of Health, 1996).

Purpose of the model
A nursing model serves a variety of functions: to define or describe something, to assist with the analysis of systems, to specify relationships and processes, and to represent situations in symbolic terms that may be manipulated to derive predictions. The purpose of this model is to describe the relationships among the concepts of empowerment, partnership, participation, cultural responsiveness, and community competence within a community organizing context (Fig. 1).

Key concepts and relationships in community organizing
Empowerment is viewed as a process whereby community members take control over their own lives and environment. This process builds on the inherent strengths and abilities that already exist within the community. An empowered community is a competent community. In Webster’s New World Dictionary (Neufeldt et al., 1988), competence is defined as having sufficient resources to take care of one’s needs. This implies the ability to deal effectively with unexpected problems or threats to well-being. On the other hand, powerlessness is an inability to affect one’s destiny. This powerlessness is not just a subjective feeling of a lack of power or control over one’s own destiny but also an objective lack of social, political, and economic power to effect change in a complex and often forbidding society. Powerlessness has been found to be a strong risk factor for illness and disease (El-Askari et al., 1998; Wallerstein, 1992). It follows that empowerment would be a strong protective factor against disease and illness.

In order to increase community competence, it is necessary to facilitate the empowerment of the individual community members as well as the empowerment of the community as a social unit. It is important to make the distinction between empowerment of the individual, which focuses on gaining skills and increasing self-esteem, thereby increasing control over one’s life, and empowerment of the community, which focuses on increasing citizen participation, strengthening social networks, and increasing a sense of community identity (Israel, Checkoway, Schulz, & Zimmerman, 1994; Wallerstein, 1992). Participation in shared problem solving is one method of increasing community competence through empowerment. With each success as a problem-solving unit, the community increases its sense of shared identity and its problem-solving ability (Eng, Hatch, & Callan, 1985). Community participation is an essential ingredient in each phase of the Nursing Model of Community Organization for Change. According to Arnstein (1969), “Citizen participation is citizen power” (p. 216). Arnstein visualizes participation as multileveled with true participation at the levels of partnership, delegation of power, and citizen control. It is at these levels of participation that citizens are responsible for program management, policy setting, and decision making. In the Nursing Model of Community Organization for Change, community members are given the opportunity to discover that through participation they can promote change and that by working together they will increase their power as individuals and as a community.

Community partnership requires a sharing of power and responsibility, not simply getting people to do what health professionals think they should be doing. “Only when issues are selected by the community itself can a real sense of ‘ownership’ emerge, and this sense of ownership of the organization is critical to empowerment and to the ultimate development of competent communities” (Minkler, 1990, p. 271). Community competence refers to the ability of the community to engage in effective problem solving. Collective analysis of the community’s strengths and needs is of paramount importance if the community is to reach its current objectives and future goals.

Cultural responsiveness plays a key role in community organization. In order to develop good working relationships based on trust, the community health nurse (CHN) must take the time to understand the cultural factors (beliefs, values, and customs) that affect interpersonal relationships. He or she must find out about the cultural make up of the community and must learn about the history of the different ethnic groups in the community (Gonzalez, Gonzalez, Freeman, & Howard-Pitney, 1991).
In addition, when working with communities, it is important to be aware of the cultural factors that influence the meanings of health and illness from the perspective of the community members. Cultural influences affect health-seeking behaviors (Chrisman, 1977) and, therefore, will have a direct effect on community health and on the acceptance by community members of any health promotion project.

Although specific health-seeking behaviors are unique to each individual, there are patterns that can be identified based on common findings in the explanatory models (Kleinman, Eisenberg, & Good, 1978) and illness belief systems of a given culture. Care should be taken to be sure that the various cultures in the community are represented among the community volunteers working on program planning. Because these community members will be designing the interventions for any given health issue, the hope is that the interventions will then be culturally relevant and appropriate. Cultural factors will also have an effect on the acceptance of the principles of self-help, felt needs, and participation. These principles are not necessarily valued or even viewed as desirable in all cultures (Stone, 1989).

**DEFINITIONS OF CONCEPTS**

The concepts and definitions that are associated with the Nursing Model of Community Organization for Change are shown in Table 1.

**ASSUMPTIONS**

Identifying the assumptions that are inherent in a theory or model is necessary to improve understanding of the model and its applications among readers. The assumptions identified in this model include the following: (1) Increased community competence will lead to improvements in community health. (2) Participation promotes learning. (3) Community participation increases the probability of program success. (4) Culture influences community health-seeking and health-promoting behaviors. (5) Sustainability depends on community participation.

**PHASES OF COMMUNITY ORGANIZATION**

The four phases of community organization are community assessment/reassessment, planning/design, implementation, and evaluation/dissemination. The phases do not occur in a linear fashion but overlap and intermingle throughout the community organization process. Stringer (1996) describes this process as “a continually recycling set of activities” (p. 17). For example, there will be the need to evaluate at each stage of the process. This enables the planners to make necessary changes at the time they are needed. A brief description of each phase of the community organizing process integrated with the concepts of empowerment, participation, partnership, community competence, and cultural responsiveness follows.

**Community Assessment/Reassessment**

Assessment is ongoing throughout the community organization process. Initially, it involves gathering historical and current information about the community. Data-gathering methods include analysis of vital statistics and community health profiles, performing a windshield survey, talking with community members, studying the history of the community, and learning about the cultures represented in the community (Gonzalez et al., 1991). After these information-gathering activities, the CHN should be able to define the community of interest. Defining the community “is a necessary step in determining where community members are and how to reach and organize them” (Kinne, Thompson, Chrisman, & Hanley, 1989, p. 226).

Once the community is clearly defined, the assessment process will be one of increasing community involvement. It is necessary to identify key organizations such as churches, service clubs, local health care providers, schools, and social groups. Attending meetings and other community events will help to identify community leaders. These resources will be the building blocks for increasing community competency (McKnight & Kretzmann, 1997). Participation in voluntary associations and strengthening social networks through

| TABLE 1. Major Concepts in the Nursing Model of Community Organization for Change |
|-----------------------------------|----------------------------------------------------------------------------------|
| Empowerment                        | The process by which individuals and communities develop an awareness of their inherent problem solving skills and resources. |
| Partnership                        | A working relationship built on mutual respect, exchange of ideas, and shared power. |
| Participation                      | The community members are engaged in all phases of community organization and have decision-making authority. |
| Cultural responsiveness            | The ability to adapt methods and plans to incorporate the cultural factors that influence the meanings of health from the perspective of the community members. |
| Community competence               | The ability of the community to collaborate effectively to manage threats to well-being and move toward the goal of improved health. |
partnership are two additional means of empowering communities (McKnight, 1987).

At this point in the process, it is time to form a community advisory group (Kinne et al., 1989). This group should be composed of community members who have shown an interest in being involved and are representative of the community as a whole. The assessment now becomes their assessment of the community’s needs and assets. This process should involve the entire community through community meetings, surveys, in-depth interviews, and focus groups. Assessment of the community’s assets allows community members to recognize the potential contributions of each individual (McKnight & Kretzmann, 1997). It allows community members to see themselves in terms of what they have instead of what they do not have. Assessment of the community’s “felt needs” helps to establish trust between the CHN and the community (Gonzalez et al., 1991) and is the first step in establishing community ownership of the program. Once assets and needs are identified by the community members then planning can begin.

**Planning/Design**

Planning is the process of setting goals and objectives and then designing the interventions necessary to meet the objectives and reach the goals. Part of the CHN’s job is to help the community select goals that are “winnable and specific” (Minkler, 1990, p. 271). This will promote early successes, which in turn will promote an increased sense of community. If the community sets the goals and designs the interventions, then the program will be theirs. This gives the individual community members a sense of power and control over their environment, which are two important factors in empowerment (Wallerstein, 1992).

The community advisory group should coordinate the planning process with technical assistance from the CHN. This is an essential part of ensuring that the program will be maintained when the CHN leaves. The CHN acts as a technical advisor and catalyst. The temporary nature of the role of the CHN in this process is an essential aspect of community organization (Kinne et al., 1989). Specific plans for sustainment of the program should be included during the planning phase. Plans for program evaluation should also be developed at this time. Careful planning of goals and measurable objectives will facilitate the evaluation process later (Stringer, 1996). The CHN’s role is also one of resource person. He or she will need to be able to provide information about fundraising, methods of health promotion, goal setting, and other technical advice as needed. The CHN should also help to arrange for any needed training of community volunteers in whatever health issues are going to be addressed.

**Implementation**

Implementation involves preparing a timeline for completion of each program objective, obtaining the necessary funding, collaborating with agencies outside the community as needed, recruiting additional community volunteers needed for program implementation (Gonzalez et al., 1991), and actually putting into action the interventions designed during the planning phase. These activities provide many opportunities for community members to develop or improve skills in leadership and team building, to increase their understanding of the politics involved in implementing a community wide plan, and to learn about grant writing and other methods of funds acquisition. Development of leadership skills is vital to the sustainability of the program (Minkler, 1990). The CHN should serve as a support person by facilitating communication among volunteers and encouraging use of the networks identified during the assessment phase.

**Evaluation/Dissemination**

The evaluation phase of community organizing is critical in identifying both successful and unsuccessful aspects of community-level projects. Effective evaluation captures the short- and long-term changes that occur as a result of the community organizing efforts. Short-term changes include community collaboration, participation, and action toward health change; long-term changes relate to health outcomes (Minkler & Wallerstein, 1997).

Two methods of evaluating community-organizing projects are process evaluation and outcome evaluation (Francisco, Paine, & Fawcett, 1993; Gonzalez et al., 1991). Process evaluation begins when the community organizing begins and is a means of evaluating what is working and what is not working throughout the organization process. This is an important element because identifying what is not working is crucial to the success of the program. Identifying what is working is necessary to point out early successes to the community members. Process evaluation is especially important in community organizing, where the process itself serves as a means of increasing community competence by “development of local initiative, individual and community self-reliance, self-confidence, and a cooperative spirit” (Foster, 1982, p. 187).

Outcome evaluation is examining what has been accomplished as a result of the program (Gonzalez et al., 1991; Pirie, 1990). How effective were the interventions? Did the program meet its stated objectives? Were there any unexpected outcomes? Has community competence increased? This information can be obtained through focus groups, outcome surveys or specially designed measurement instruments (Israel et al., 1994). Depending on the type of program and the program objectives, there
may be quantitative as well as qualitative data to analyze. Process and outcome evaluations should be performed by the community advisory group as well as by an independent evaluator (Francisco et al., 1993). The use of an independent evaluator provides objective data for comparison with the advisory group’s data.

The information gained from evaluation of community organizing outcomes must be disseminated throughout the community. This information serves to guide the community in the development of strategies to sustain programs or pursue different directions in program development.

Communication of such information can be accomplished in a variety of ways. Diffusion of information via oral and written reports to key groups with a vested interest and commitment to the community organization process is vital. Key groups include program leaders and participants, media representatives, potential support sources, and other organizations (Bracht & Kingsbury, 1990).

**CONCLUSION**

Community health nursing reaches beyond the individual and creates interventions that affect the community as a whole. Through community organizing techniques, the CHN has the potential to mobilize citizens and communities into action to affect community health positively. Community members need to be involved and invested in every phase of the community organizing process in order to assure community ownership and sustainability of the program once the CHN leaves.

This Nursing Model of Community Organizing for Change demonstrates how incorporating the concepts of empowerment, partnership, participation, cultural responsiveness, and community competence throughout all phases of the organizing process can lead to lasting improvements in a community’s health-promoting behaviors and overall health status.

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