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Promoting health at the grass roots
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Because most Americans have so little sense of community, we pay a great deal of attention to it. This attention spills over into the field of public policy, where both conservatives and liberals use the term grass roots as if it were herbal medicine to cure public problems and to renew American social health. Obviously, with this amount of consensus among politically disparate groups, there has to be a great deal of misunderstanding. Our consensus is due, in part, to our rose-tainted view of community and the processes we describe as empowerment, community development, and community organizing. In this Commentary, I refine and compare types of community-based organizations, all of which we term grass roots.

These distinctions are crucial to realistic expectations of grass-roots programs in any field, including health promotion. Realistic expectations, in turn, will preserve the democratic promise of grass-roots programs and improve their effectiveness. Grass-roots programs bear our hope to reach groups in severe need with effective programs and to reduce inequalities among groups of Americans. Some of the most striking inequalities among Americans exist in health status, health care access, and health risks. The new set of health objectives for the nation specifies targets for the poor and for African-Americans in sixty-two of its objectives. There is, of course, no claim that grass-roots programs will solve public problems at no cost, without public resources, or without controversy.

Representation and participation. Reaching people at the “bottom” is not a bottom-up approach. Forms of representation and participation in program decision making distinguish bottom-up from top-down approaches. A. Alexander Chauncey, for example, offered three types of representation: technical, modal (both indirect), and sociopolitical (di-
Technical representatives have special knowledge, real or ascribed, about a group. They are not members of a group but speak on their behalf. Service providers or academicians, for example, may “represent” a group such as the young or the homeless in the sense of speaking about them. Modal representatives have some demographic criteria in common with a group—income, age, race, gender, or status—that others interpret as qualification to represent a group. Sociopolitical representatives may claim special authority for their views because some organized group or portion of a group delegates them to speak for it. They may have modal characteristics or technical knowledge as well. In another form of direct representation, members of a group may represent themselves.

Better understanding of participation came with expanded forms of representation in the 1960s. Sherry R. Arnstein assembled a ladder of participation that extended from citizen control to manipulation. In between were degrees of effective and ineffective participation. The ladder of participation permits us to recognize degrees of influence and power in various forms of participation.

Jack Rothman clarified community organizing by distinguishing between locality development, or what I term community development, and social action, or community organizing. He distinguished them by their varying forms of representation and participation. These two models of community organizing differed from social planning that had token representation and nonparticipation of those affected by decisions.

**Empowerment.** Empowerment is an essential ingredient in all grassroots programs. Some understand it as a form of health promotion in and of itself or a means to promote health. The American Enterprise Institute used the term more broadly to extol an approach in public policy and social service provision. But empowerment, like the other terms, has distinct forms and stages. All forms of empowerment involve the transfer of information, skills, and resources that improve the decision-making power of individuals or groups. But whether that transfer is primarily to an individual or to a group and whether it is voluntary or involuntary distinguish approaches to empowerment. Some approaches collect individuals as members of a group (diabetics, for example) and transfer skills and information to them to deal with the condition that makes them a member of the group. Other approaches to empowerment identify groups (neighborhood residents, for example) and transfer information, skills, and resources to its members through organized action for some common benefit.

Whatever its form, empowerment begins with the realization of a person or a group that a condition, problem, or need is not theirs only,
but that others have it as well. Empowerment continues when individuals or groups begin to relate to others in new, supportive ways, precisely because of the common conditions, problems, or aspirations that they share. A group’s resources increase as its members discover new competencies among them to deal with a particular problem.

Most discussions of empowerment, especially in health care and health promotion, end here. This is the form of empowerment that service providers imply when they talk of “empowering” clients or patients to do what service providers hope they will do. This stage of empowerment also coincides with the strategies of self-help groups that are an important component of behavioral change programs. The self-help ethos stresses the individual need to gain control of oneself, one’s environment, and the factors that affect day-to-day living. While numerous characteristics define the self-help movement, the most important center on the sense of self-empowerment, self-determination, mutuality, and bottom-up orientation.\(^{11}\)

The emphasis of self-help on self-determination and individual control ignores the risks that are beyond individual control. Reducing risks to one’s health may require changing the behavior and actions of others, as John B. McKinlay explained about polluters.\(^{12}\) Similarly, the death of a young victim of a drunk driver may indicate how risks to life remain despite the victim’s participation in an alcohol and substance abuse program.\(^{13}\)

Another form of empowerment, one that is explicitly political, is organized action for group benefit. It empowers individuals in the process of organized action to acquire new resources by imparting indirectly the skills and information needed for group action, beyond self-help. It is more likely to address generic risks to health, such as poverty; policy matters, such as pollution; and the behavior of some that risks the health of others, such as drunk driving. This form of empowerment may involve the involuntary transfer of information, control, and resources from one group to another, which distinguishes it further. In self-help, the transfers are cooperative and voluntary. Group empowerment not only seeks transfers of resources from people who do not volunteer them, it also explicitly demystifies authority much more than do self-help efforts. It fosters new attitudes toward authority and self. Specifically, empowered groups are more likely to challenge experts and those in charge. They may even consider those in authority as part of the problem they are addressing and challenge officials about their role in the condition or need of the group. Groups at this stage of empowerment are more likely to view themselves as part of a social movement of political, social, and economic change than as part of a self-help group.\(^{14}\)
A Taxonomy Of Community-Based Organizations

A variety of organizations fit under the rubric “community-based.” These are defined below.

**Grass-roots groups.** Grass-roots groups are membership organizations of people directly affected by a problem or condition. There is a heavy emphasis on membership participation and governance. Members of these groups ordinarily organize to gain the attention of public officials. They do not ordinarily provide services initially but depend upon those with whom they may conflict to acquire services or needed regulations from others. Their members share common concerns about a particular issue or set of issues related to the area in which they live, the place they work, or some common problem or opportunity. Ordinarily, these groups are staffed by volunteers or part-time employees. Numerous local environmental groups and neighborhood organizations illustrate this type of organization.

**Grass-roots services.** At this level, grass-roots activities serve people instead of organizing them. They may treat the people they serve as members of the service but only to the extent of partial participation. The decision-making boards of grass-roots services are most likely to have members who are primarily resource providers. They may also have service providers and modal representatives of the people served. Grass-roots services often provide a support network for people in crisis and help people to reestablish old support networks or to establish new ones. Domestic violence shelters and storefront health centers are examples of grass-roots services. Such services have a wide range of sizes and budgets and are difficult to sustain because they offer unreimbursed services.

**Grass-roots organizations.** These membership organizations are the horizontal integration of grass-roots groups or services. Some grow from the need for a larger coordinating mechanism, such as a statewide coalition of domestic violence shelters or hunger groups. Others begin with the task to proliferate local chapters and groups, such as a committee on occupational safety and health. They may vary widely in focus and number of issues, but they all feature direct forms of representation for their member groups and full participation in the organization’s policy and decision making.

**Voluntary services.** This type of activity addresses a need for services such as health education; examples are the local chapters of the American Heart, Lung, Cancer, and Diabetes associations. The primary focus of these groups is to provide an array of educational and limited direct services. They differ from grass-roots services in the broad audience they intend to serve. Likewise, their ordinary intervention is less crisis-ridden
and less intensive. They are more likely to have a permanent and professional staff, although the resources of the groups can vary widely. There is heavy dependence on volunteers to provide services, and a major portion of staff time is devoted to coordinating volunteers. Members of voluntary services are more likely to be financial contributors and prominent local leaders than to be those who receive services. Consequently, their governance boards provide low-income groups only indirect representation and partial participation at best.

**Voluntary associations.** Voluntary associations are regional or statewide organizations of voluntary services and parallel them in many ways. They may vary by the degree of accountability to local service providers. Some may be top-down organizations directing the conduct of local chapters, and others may be directed by a board of representatives of local services or chapters. Voluntary associations are more likely to engage in advocacy for new or improved related services or regulations than their constituent members. State chapters of the American Heart, Lung, Cancer, and Diabetes associations are voluntary associations.

**Community agencies.** These agencies extend a set of well-defined, professional services to a designated group of people in a specific area; examples include schools, churches, and public health centers. These agencies have a set of priorities for the concerns they address and the services they conduct. They may address additional needs, if asked, depending on the discretion of the people in charge and how they relate those additional needs to their ordinary professional services. They may extend modest assistance, such as the use of facilities, or they may modify services, such as incorporating a health curriculum in a school program. These agencies may have some forms of full participation and direct representation for clients and local residents, but only in modest segments of agency programs. Lines of authority are formal. Their funding sources are generally outside of the local community and figure prominently in decisions about what a community agency can and cannot do. Community agencies have professional staff and generally operate under the guidelines of an external authority.

**Community coalitions.** Coalitions combine and coordinate community-based organizations that have common concerns about a particular issue. Generally, they provide no direct service and exist on the effort and time contributed by members. Community coalitions provide member groups with direct representation and full participation. The more disparate its members, the more difficult it is for a community coalition to articulate a clear position and to pursue action related to it. On the other hand, the broader its membership, the greater the credibility a community coalition may claim for its work and position and the more avenue it
will have for resource transfers. Community coalitions are generally temporary. Specific programs they may develop generally become separate organizations. The Planned Approach to Community Health (PATCH) interventions of the Centers for Disease Control are examples of community coalitions. They are distinct from grass-roots organizations by their diverse makeup and temporary nature.

Outreach programs. Through outreach programs, limited and temporary services are provided by one set of people with skills through a set of community agencies or grass-roots groups and grass-roots services that ordinarily do not provide the services. Hospital health fairs in community centers are examples of community programs. The services are of limited duration to a specific area. Staffing and resources are borrowed from voluntary services and voluntary associations as well as from sponsoring groups. There is informal governance among participating groups that have direct representation but only partial participation. The sponsoring groups make decisions with advice from those participating or served.

Grass-Roots Health Promotion Programs

The variety of community-based organizations correspond to different health promotion strategies. Grass-roots groups might organize to acquire the resources of others for the provision of self-help programs, without actually providing the services. Grass-roots services and voluntary services are more likely to provide programs to change or maintain individual behavior. Community agencies and outreach programs can help to implement these services by supporting them, providing a place for their conduct, or permitting service providers to explain their program to people within the community agency.

Beyond lifestyle, however, improving preventive services and working for regulatory change to benefit high-risk groups, especially those with low incomes, are likely to entail the explicitly political stage of empowerment and community organizing. It involves the acquisition of resources to provide services and regulations that are needed but not currently available. This most often requires some form of organized action to demonstrate a need and to accumulate sufficient influence or numbers of people to warrant a change. Acquiring the change often also entails some degree of conflict if the new services or regulations require a reallocation of resources or changed behavior on some group’s part. Grass-roots organizations express the effort of grass-roots groups and services to go beyond local efforts of self-help to organized action for group benefit. Likewise, community coalitions pursue changes in regulations and the
provision of additional services and have less capacity to conduct programs of behavioral change. Grass-roots groups, grass-roots organizations, and community coalitions have the most organizational capacity to acquire regulatory change and preventive services. Conversely, grass-roots services, voluntary services, community agencies, and outreach programs have the greatest capacity to provide programs of behavioral change and preventive services. This distinction corresponds to approaches of community organizing and development.

A grass-roots approach to health promotion entails an array of organizations, strategies, and levels of empowerment. Specific programs will vary, but their effectiveness will depend on a constellation of organizational characteristics and strategies. By recognizing the unique patterns of representation and participation, proclivities for forms of change, and levels of empowerment to which community-based organizations normally aspire, we may be better able to align them with appropriate health promotion strategies. Finding the best fit is essential to effective interventions in low-income, high-risk communities and to the transfer of information, skills, resources, and decision making that is the meaning of empowerment.

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NOTES


7. Rothman, “Three Models of Community Organizing Practice.”


