ANALYSIS AND OBSERVATION

OF THE CONCEPT OF COMMUNITY HEALTH

By

Mary Jo Baisch, M.S., R.N.

A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

In Nursing

at

The University of Wisconsin – Milwaukee

May 2006

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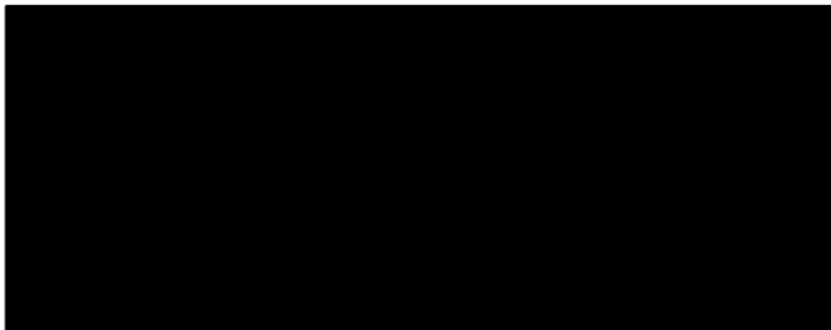

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Abstract

Analysis and Observation of the Concept of Community Health

by

Mary Jo Baisch

University of Wisconsin-Milwaukee, 2006

Under the Supervision of Beth L. Rodgers, PhD, RN, FAAN

The concept of *community health* has varying meanings for those in different professional disciplines and for community residents. The aim of this study was to analyze this concept using Rodger's Evolutionary Method of Concept Analysis (2000). The study design included three phases. In Phase I, the attributes of *community health,* the sociocultural context surrounding its use, and related concepts were identified in professional literature sources. In Phase II, the Phase I results were compared with the attributes of the concept identified in six community health assessment instruments. The findings of the first two phases were then compared with the perceptions of expert informants in community health in the United States.

A definition of *community health* was derived from the professional literature that was not consistently supported in the interviews and community assessment instruments. This definition is: *Community health* is a dynamic condition defined by its members through participatory action in partnership with professionals defined by the community members and based on the philosophical beliefs of community development and empowerment. Its focus is on health promotion and disease

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prevention for the entire population within it using an ecological model of health improvement and including broad determinants of health. Based on the needs of each community, community health is defined differently.

The context in which *community health* occurs is rooted in social justice, yet takes place in a global economy with wide disparities in wealth and fewer resources for community development and health improvement. Surrogate terms included "population health" and "public health" and related concepts were community, health, primary health care, and community development.

Through the informant interviews and the literature, it was evident that the concept of *community health* is applied differently by individuals within and across disciplines. This study offers a foundational definition for future research, education and practice. This concept is central to the improved health of populations and a clear definition of the concept will support clearer communication among and within disciplines and community members.

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Chapter One: Introduction

The concept of *community health* has varying meanings for different individuals and groups of people. To some it means the provision of health care in the community; for others it is synonymous with "public health." Yet communities across the country are invested in the process of assessing their health and developing plans for the redistribution of resources so that the health of their communities can be improved. This is being done without a clear definition of the concept. What does it mean to be a "healthy community?" Is this a different concept than that of *community health*? These concepts are often confused with others, such as primary care, primary health care, community medicine, community health promotion, population health, and public health. The concept of *community health* is central to the improved health of population groups and a clear definition of the concept is needed as a basis for practice, research, and education in many disciplines such as nursing, medicine, anthropology, sociology, and public health.

A clear conceptual definition offers an improved ability to explain, categorize, and describe situations and phenomena (Avant & Abbott, p. 324). By clearly identifying the attributes of the concept of *community health*, researchers and educators will be better able to describe the contextual issues surrounding the concept for students and practitioners in the health professions and other disciplines that study social institutions. Without a comprehensive explication of the concept, academicians, researchers, and practitioners may be unclear about the tenets and scope of the concept of *community*

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health.[1] The answers to these questions are needed to communicate more clearly what is meant when discussing, teaching, and researching *community health* and will enhance the use of the concept in future research and practice.

This study occurs at an opportune time. The Institute of Medicine (2003) published its second report concerning the status of and trends in public health in the United States. This report builds on the experiences of the past two decades learned through the Healthy Communities initiatives and the national Turning Point programs that have been funded through the W. K. Kellogg Foundation and the Robert Wood Johnson Foundation. It expands upon the groundwork that was laid in the first Institute of Medicine report, *The Future of Public Health* (1988). In this report, committee members defined p*opulation health* and *public health system,* but did not differentiate these concepts from the concept of *community health.* Because of the confusion in definition of the concept of *community health* and the need for conceptual clarity, this study was designed to systematically analyze the various conceptual definitions of *community health*

- as it emerges from the professional literature,
- through its use in community health assessment instruments, and
- through the testing of the emerging characteristics of the concept by key community health professional representatives.

As a concept, *community health* often is used interchangeably with public health, yet many authors believe they do not refer to the same concept (Salmon, 1995; Sills &

[1] Italics are used throughout the document to designate reference to a concept, ie. the concept of *community health.* Terms are used throughout the document within quotation marks.

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Goeppinger, 1985; Turnock, 2001) and often there is confusion in the use of both terms. There is an implication in some categorizations that public health refers to governmental health functions. Yet even the nomenclature of governmental agencies accountable for the health of its community members is confusing. Although Wisconsin describes the governmental entity responsible for the health of its citizens as the Division of Public Health, the corollary in Michigan is entitled the Department of Community Health, implying that both governmental entities are responsible for their respective communities. In this case, the use of the terms "public" and "community" have similar meanings. A dictionary definition of the word "public" supports this confusion with the definition: "of pertaining to, or affecting the community or the people as a whole" ("Caucus seeks to bring faith communities and public health together", 1996). Similarly, during the development of *Healthiest Wisconsin 2010* (Wisconsin Department of Health and Human Services, 2001), the state health plan, there was much discussion of the appropriateness of the use of either the term "community health" or "public health" when defining the outcome of the work needed to improve the health of Wisconsin residents. In the final decision the term "public health" was used, based on the consensus that the term "public health" referred broadly to the "health of the public" (Schmelzer, 1999).

The conceptual confusion also has been evident as members of various initiatives have attempted to develop and improve the health of their communities without clearly knowing what constitutes the concept. The Healthy Cities movement that began in Europe and Canada in the mid 1980s and expanded as the Healthy Communities initiative in the United States developed a common definition through the World Health Organization: "A Healthy City is one that is continually developing those public policies

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and creating those physical and social environments which enable its people to mutually support each other in carrying out all functions of life and achieving their full potential" (Awofeso, 2003, p. 1). This process oriented definition is grounded in a belief in community membership and participation, rather than a more structural definition that describes a governmental entity. While the W.K. Kellogg Foundation (1997) initially funded projects to improve community health at the local level, the Robert Wood Johnson Foundation (RWJ) (1996) began to address the governmental health issues through its Turning Point project. The goal of Turning Point was to "transform and strengthen the current public health infrastructure so that states, tribes, communities, and their public health agencies may respond to the challenge to protect and improve the public's health in the 21rst century". This goal leads to more confusion with the implication that the public health infrastructure included states, tribes, communities, and their public health agencies. Although a Turning Point report (Couto, 2000) described the public health infrastructure as including community, the implication was that although overlapping, the concepts of *public health* and *community health* are quite different.

Views of community health vary depending upon who is defining the concept. As a social enterprise, the values of constituents often affect the definition, yet professionals usually identify, develop and implement the associated goals and services for the population being served (Flynn, 1996). Health professionals historically have viewed community health from a disease orientation, using health statistics to define a community through the vital indicators of its populations, such as morbidity and mortality (Turnock, 2001). This problem oriented (and more reductionist) approach does

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not allow for exploration of health from a wellness perspective (Sirianni & Friedland, 2001). Sociologists view the community from its social institutions and processes, such as governance and community participation (McKnight, 1992; Sirianni & Friedland, 2001). Through this lens, community health is accompanied by a participatory action research agenda, including the identification and establishment of health policy and other forms of community development At various times, members of a discipline may describe the study of the health of the public as community health (Boswell, 1992), population health (Institute of Medicine, 2003), public health (Kalnins, 2001; Quad Council of Public Health Nursing Organizations, 2000; Turnock, 2001), community medicine (Deuschle, 1983), or a combination of the terms, such as community/public health (APEX/PH Work Group, 2001; Association of Community Health Nurse Educators, 1993).

Difficulties also arise when identifying *community health* as a discipline. When it is considered a discipline, community/public health is described as multi or inter-disciplinary in nature (Institute of Medicine, 2003; Turnock, 2001) and it is a recommended subject area for baccalaureate prepared nurses (Association of Community Health Nurse Educators, 1990; Quad Council of Public Health Nursing Organizations, 2002) and medical students (Association of Community Health Nurse Educators, 1990; Deuschle, 1983). Yet, without a clear definition of the boundaries, scope and/or content of the concept, there are researchers who question whether community health can even be considered a discipline (Afifi & Breslow, 1994). Laudan described not only the link between conceptual problems and theory development, but also the interdisciplinary nature of knowledge development as conceptual problems arise (Laudan, 1978). With

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this confusion it is evident that a clear definition of the concept is essential to the development of knowledge concerning the health of communities. By analyzing the concept in various disciplines, the conceptual problems will be more clearly identified and a more comprehensive definition will be developed. For these reasons, this study has been designed not only to clarify the issues surrounding this concept, but to identify a clearer definition of the concept of community health.

Problem Statement

The aim of this research is to analyze the concept of *community health* in an inductive, non-sequential, iterative process using the Evolutionary Method of Concept Analysis developed by Rodgers (2000, 1993) in which the contextual history and applications of the definition are explicated. Specific research questions include:

- What are the predominant attributes of the concept of *community health* presented in the literature of the disciplines of nursing, medicine, public health, anthropology, sociology, and urban planning and how do they vary across disciplines?
- How does the concept vary in light of the context surrounding its evolution as presented in the literature?
- How is the concept of community health operationalized in community health assessment instruments?
- How does the concept as identified in the literature compare with the concept as operationalized in community health assessment instruments?
- How do the attributes of the concept of community health as it has evolved in the literature and as operationalized in assessment instruments compare with the ideas

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of key informants including those practicing community/public health professionals and community leaders?

Through a comprehensive analysis of the concept of *community health*, a solid conceptual foundation will be identified that may serve as the catalyst for research into other issues, such as how does the identified conceptual definition vary among different population groups? A clear definition of the concept will also provide a basis for the development of guidelines and procedures for local communities as they determine what is considered within the scope of community health in their jurisdictions and what guidelines or procedures should be used to allocate resources to improve the health of their constituents. Without a clear definition of the concept among various disciplines, it will be difficult for students of community health to define their roles and functions.

Assumptions

This study is based on the assumption that a description of the concept of *community health* will emerge from the professional literature concerning attributes and concerning the concept and in the language of the interviewees. The method identified for this study also requires an assumption that interviewees will articulate their ideas related to the concept of community health accurately and with integrity. Furthermore, it requires an assumption that the attributes of the concept of *community health* can be identified in community health assessment instruments.

Summary

Parse (2002) recently wrote, "Words, Words, Words: Meanings, Meanings, Meanings! Using words that convey intended meanings about ideas facilitates understanding (p.183)." The concept of *community health* has different meanings to

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different individuals and groups. This purpose of this study is to identify the common characteristics of the concept of *community health* as it is currently used by members of the health professions and other disciplines. These characteristics will be synthesized to develop a theoretical model for the concept and thus, to promote a clearer understanding of *community health* on a conceptual level.

In this chapter the conceptual issues and the implications for research and education are summarized. The following chapters include a review of the literature, the proposed methodology for the study, results of the three components of the study, and conclusions and recommendations.

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Chapter Two: Background and Significance

Although "community health" is used often in the literature and in practice, its meaning is often unclear. This chapter begins with the literature regarding the need for conceptual clarity and the process of concept development and analysis. In order to better identify the attributes and the issues in community health, the concepts of both *health* and *community* are first defined. This is followed by the interpretation of the concept of *community health* by various disciplines involved in community health practice. These interpretations of these disciplines are often overlapping and confusing. As "community health" is interdisciplinary in nature, the views and conceptual issues concerning the concept of *community health* in public health, nursing, the social sciences and medicine are included as well as the implications of these issues for further research.

Need for Conceptual Clarity

The purpose of scientific endeavors is to build a body of knowledge in a specific discipline (Avant & Abbott, 2000; Kuhn, 1996; Laudan, 1978; A.I. Meleis, 1997; Toulmin, 1972). Philosophers and scientists continually refine the processes of knowledge development in which specific concepts identified through research or other means can be linked to build theories, which can be further researched and evaluated. Toulmin (1972) described the process of developing disciplinary knowledge as building "changing populations of concepts" (p.133). Identifying these changing concepts can be even more confusing when the area of interest involves multiple disciplines, such as those involved in improving community health.

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The various taxonomies used to describe health care document a conceptual base that has changed over time. The International Classification of Diseases has been revised 10 times since its initial publication. Concepts that describe the scope of nursing practice in community health (Martin & Scheet, 1992) and nursing interventions (Martin & Scheet, 1992; McCloskey et al., 1996) have been developed in taxonomies since the 1980s. Members of the Council of Omaha Systems, International (COSI) identified those terms in the OMAHA taxonomy that best describe current community health nursing practice (March 3, 2001).

Meleis (1997) described the need for concept exploration in two cases: when a new concept is introduced into the literature or when a concept is so familiar that its definition is taken for granted. In this case, the use of the term "community health" became more evident in the literature in the 1980s and has now become so commonly used that the meaning has become unclear and often confused with the term "public health" and other concepts such as "primary health care."

Rodgers (2000) identified the need for conceptual clarity to promote more effective communication through more accurate definitions. The various classification systems described above provide opportunities to make more nebulous concepts like illness or nursing practice more explicit. The focus of this study is a critical first step in the development of knowledge about the broad concept of community health by determining the attributes and contextual factors associated with the concept. Through a systematic process, the varying definitions of the concept will be synthesized and described so that researchers and practitioners are more aware of the complexity involved

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in this concept and can pursue their research and academic endeavors from a solid conceptual foundation.

Definitions of Health

The World Health Organization's definition of health was used often by both community and public health practitioners: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1978). This definition calls for a level of health that permits people to lead socially and economically productive lives. This definition presents health as a dynamic state that can be approached but not attained, and links social and economic conditions to individual health. This is in contrast to an earlier historical definition. William Welch, the first director of the School of Hygiene and Public Health at Johns Hopkins University stated, "It is a well known fact that there are no social, no industrial, no economic problems which are not related to health" (Winslow, 1952, p. 3). Although linking socioeconomic conditions with health, this definition is stated from a more problem oriented view.

More recent definitions include descriptions of health as more than individual and biomedical problems (Barnes et al., 1995). The World Health Organization's (WHO) Ottawa Charter (1986) listed the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The earlier definition of health outlined at the WHO Conference at Alma Ata was expanded in the Charter to include the health of groups:

> To reach a state of physical, mental and social well being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or

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cope with the environment. Health is therefore, seen as a resource for everyday living, not the objective of living (p. 1).

The Ottawa Charter further stated that "good health results from changes in the environment which comes about by participation in the public policy process" (p. 1). This definition is consistent with that of "community" as a collective, in a process of empowerment (Sirianni & Friedland, 2001). The WHO definitions promote a view of health that is positive, based on a model of health promotion and community participation. This view is much more focused on the health of populations and wellness and is a switch from the definition of health as the absence of disease.

Community health nursing leaders have defined "health" in various ways. Smith (1981) summarized several of these definitions reflecting a continuum of comparative states: "Clinical health, the absence of disease; role-performance health, the ability to satisfactorily perform one's social roles; adaptive health, flexible adaptation to the environment; eudaemonistic[2] health, self-actualization and the attainment of one's greatest human potential" (p. 43). Clark (1999a) defined the "dimensions of health" as the variety of influences that affect humans. These include "biophysical, psychological, physical, social, behavioral and health system" (p. 73). The physical dimension refers to the physical environment, while the biophysical refers to human physiology. These more recent descriptions include definitional components that result in attainment of potential, and reflect all aspects of human life and can be directed not only toward individuals but toward specific population groups or the "community."

[2] A model of health "in which health is viewed as self actualization and the attainment of one's greatest potential (Stanhope & Lancaster, 2004)

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Definitions of Community

In an article in a Midwestern suburban community newspaper, lay perceptions of a "well" community were defined. When comparing urban and suburban descriptions of communities, the author contended that while "these outlying communities (suburbs) offer nice homes, bigger yards, and more privacy, qualities that appeal to the individualist in all of us. . . what they may not offer is a sense of belonging (Steimle, 1998). This definition is consistent with a growing number of authors who describe the community from a social perspective (McKnight, 1992; Raeburn, 1992). These include descriptions of a community as collective associations of groups of persons who gather in a variety of settings for a variety of reasons, i.e. for social impact, to solve problems, or those that have identifiable needs. Clark (1999a) defined community as a "group of people who share some type of bond, interact with each other, and who function collectively regarding community concerns (p. 5). In these definitions, "community" is described as a process or function, rather than a structural entity, e.g. geographic location or those with territorial bonds, such as a school or jail. Green and Ottoson (1999) described the community in this way, "Our concept of community has changed from a limited view that a city in its boundary constitutes a community to a consideration of the interaction of social norms, values, and organizations. . . We will use the term 'community' to refer to a group of inhabitants living in a somewhat localized area under the same general regulations and having common norms, values and populations" (p. 41). They differentiate a community from a population by defining a population as "any aggregate of individuals" (p. 41).

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Kretzmann and McKnight (1993), define a community through its "assets" which they describe as "capacity focused" (p. 5). This view is in direct opposition to models in which the community is defined by needs and improvement in outcomes, such as mortality and morbidity, unemployment, truancy, child abuse, etc. When using social descriptions of community, there is an inherent assumption that communities can function well or not, or be in various states of health. Descriptions of healthy communities consistent with this process view include descriptions of functioning communities as "competent" (Goeppinger, Lassiter, & Wilcox, 1982) and resilient (Bernard, 1993). "Competent" communities have been described as those that carry out the following functions:

1. Production and distribution of goods and services
2. Social control and maintenance of norms of social interaction
3. Promotion of social participation by community members
4. Socialization of community members
5. Mutual support to meet the individual needs of members (Bjorn, 1989).

Resilient communities are described as those in which "relationships are interwoven between people and institutions, meaning it supports families and schools that support youth;" as one rich in "social capital;" and one in which "people make decisions as a community" (Bernard, 1993). This social science definition of a community as "resilient" is consistent with one in which its asset capacity is enhanced. The question remains whether these attributes would be included in conceptual descriptions of *community* by professionals in other disciplines or by local residents themselves?

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"Public" versus "Community" Health

There is considerable confusion in the definitions, history, philosophy, and function of the concept of "community health" as it relates to "public health." Much of the confusion concerns the scope and content of the concept. Many believe "public health" to be a governmental function and "community health" to be much broader. Legal definitions begin to set some parameters around the concept, yet reveal the lack of clarity. Public health law has been defined recently as:

> . . .the study of the legal powers and duties of the state to ensure the conditions for people to be healthy (e.g. to identify, prevent, and ameliorate risks to health and safety in the population), and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for protection or promotion of community health. (Gostin, 2000, p. 2837)

This definition clearly presents public health as a component of the concept of *community health* and documents the idea that public health law exists for the purpose of the state, noting public health as a governmental function. This is in sharp contrast to the definition developed by the Institute of Medicine (1988) in its often quoted report, *The Future of Public Health,* in which "public health is what we, as a society, do collectively to assure the conditions in which people can be healthy" (p.1). This definition was recently reaffirmed by the Institute of Medicine's Committee on Assuring the Health of the Public in the 21st Century (2003). They wrote:

> A public health system would include the government public health agencies, the health care delivery system, and the public health and health sciences academia,

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> sectors that are heavily engaged and more clearly identified with health activities. This definition clearly demonstrates the overlapping definitions of public and community health. Communities and their many entities (e.g., schools, organizations, congregations), business and employers, and the media. . . (p.2)

The confusion is also evident in historical descriptions. Efforts to improve the health of communities were first described by the Greeks with their belief in hygiene and physical fitness. Later attempts were focused on protection of the public through communicable disease control included quarantining those with leprosy, the plagues, and other illnesses. There was little change in these activities until the industrial age. At that time microbiological research advanced the germ theory and with a growing population base, the wealthy were less able to quarantine themselves (Winslow, 1952). In Great Britain in 1842, Edwin Chadwick (Richardson, 1965) presented to Parliament a seminal report on improving health in communities. In the *Sanitary Condition of the Labouring Population of Great Britain*, he described a plan to improve sanitation, but linked poverty and ill health. In the United States in 1850, Lemuel Shattuck recommended that a complete health system be developed, including sanitation, school health, nursing education, medical education, tuberculosis control, and other activities (Shattuck, 1850). An assessment of the community of New York City followed this report in 1872 and revealed gross problems in sanitation and housing. These efforts in part led to the founding of the American Public Health Association in 1872 and demonstrated the clear overlap of the definitions of "community health" and "public health." It was during this period that the term "public health" became more frequently used. C. E. A. Winslow

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(1952), a professor of medicine and public health at Yale during the first half of this century, defined public health as:

> The science and art of preventing disease, prolonging life, and promoting physical and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections, the education of the individual in principles of personal hygiene; diagnosis and treatment of disease; and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health. (p. 30)

The history and this definition of public health, clearly refer to a more comprehensive description of public health than that of a governmental entity. Although the focus in these historical reports is on communicable disease control, these early advocates, mostly health practitioners, linked broader social issues with health. Yet these reports focused on community problems rather than descriptions of "healthy" communities.

The shift to a focus on "healthy communities" began largely with the Healthy Cities campaign, an international movement that was based on the WHO policy initiative of "health for all by the year 2000" (Kenzer, 2000). In 1983, in a joint meeting of WHO and the United Nations Children's Emergency Fund, participants agreed to study urban health with a special emphasis on countries in the Southern Hemisphere and the research of Thomas McKeown. McKeown noted that factors that improved health in the 19th and 20th centuries were based on "social, environmental, and economic changes, smaller family size, increases in food supplies, healthier physical environments, and selected preventive and therapeutic measures (McKeown & Lowe, 1974). The concept of a

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"healthy city" included mobilization and allocation of local resources, formulation of plans, application of technology, and participation of groups outside of government in coordination with local authorities (Kenzer, 2000). The effort described as the Healthy Communities initiative was expanded in the United States with funding by the W.K. Kellogg Foundation (Flynn, 1997). The concept of *community health* was used interchangeably with "healthy communities" (Flynn, 1997). With the focus on improved health for all constituents of a local community, there were again overlapping definitions of the concept that referred to improved health of the public/communities. These initiatives are consistent with the view of *community health* as a social entity.

Community Health from a Social Perspective

The link between individual and community health was reported in the Ottawa Charter (World Health Organization, 1986) and recently in the national health plan, *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) which included the statement, "the health of the individual is almost inseparable from the health of every community" (p. 3). The WHO defined community health in the Ottawa Charter as attainment of health: "Health is created . . .by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members" (World Health Organization, 1986). Similarly, Barnes et al. (1995) described a process in which nurses collaborated on a community assessment process in which community residents viewed the health of their community as the development of the human potential of their city. The processes in which these nurses were engaged resulted in community participation at a grass roots level. These initiatives are consistent with more recent policy documents in which community health is considered a dynamic state in which there is a social

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component and in which individuals and communities attempt to attain their health potential.

In further support of these views, the literature includes reports of the need to expand the philosophy of public health to a broader view of community health (Van Der Maesen & Nijhuis, 2000; Weed, 1999). International researchers submit that the epidemiologic view of public health must be expanded to include a broader view of the health of communities because "its [public health's] positivistic orientation underscores a principal weakness in its understanding of the social dynamics of health and disease, thus undermining its ability to effect change"(Van Der Maesen & Nijhuis, 2000) and because "the attribution of causal status to risk factors defined in this way has led to wasteful investment of public money in large intervention trials that are incapable of achieving their stated aims ("Population health looking upstream", 1994). Internationally, social and economic conditions that support health are much more widely included in definitions and areas of practice for community health (Flynn, 1996; Proenca, 1998). These efforts have been supported in the United States by various foundations including Robert Wood Johnson and its Turning Point initiative, the Commonwealth Foundation, the Kettering Foundation, and the W.C. Kellogg Foundation and its Healthy Communities Initiative. The Pew Commission also has supported strengthening and expanding the workforce that will be needed to work in the community (Pew Health Professions Commission, 1995).

Community health has also been defined by its processes. This is a different viewpoint from those who view *community health* as an state to which one aspires. Those disciplines that support community planning and development view community health from a community empowerment perspective, with an emphasis on hearing the voices of

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the community membership (Institute for the Future, 2000; McKnight, 1992; Sirianni & Friedland, 2001). Descriptions of "competent" and "resilient" communities assume some process as well. These views are in contrast to that of the Institute of Medicine (2003, 1988) who defined the "core functions of public health" as assessment of community's needs, policy development, and assurance that services are available to the population served. In this definition it is implied that public health professionals control the process of improving a community's health, raising not only disparate views of community health functions, but ethical considerations as well.

Gadow and Schroeder (1996) described the ethical issues in community health. They argued that when describing the "community as client," significant differences between the community and individuals are ignored and that there is the potential for the community to be placed in a more traditional professional-client role. When the community is considered a partner, the professional role becomes more clearly one of advocacy or facilitation/technical advisor rather than health education or interpretation.

Issues in Community Health Nursing

Nurses often have found it difficult to define their practice. The grand theories described by Rogers, Callista Roy, Parse, Orem and others have been found to be inadequate in their explanations of nursing as a discipline, lacking the specificity needed for contemporary research and practice. A subset of "middle range" theories have now been identified that describe concepts that have been argued as central to nursing practice, such as collaboration, empowerment, support, attachment. These concepts are only beginning to be explored from the perspective of "community as client."

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The view of the community as a client is supported historically (Association of Community Health Nurse Educators, 1990; Clemen-Stone, 1996). Florence Nightingale (Nightingale, 1859) described the community as a practice area of nursing stating "the sufferings. . .are very often not symptoms of the disease at all, but of something quite different - of the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness" (p. 1). Early public health experts, Welch and Winslow agreed that the nurse was a "central figure" in the campaign to improve the health of the public (Winslow, 1952, p. 26). Welch wrote that the modern ideal was a "public health nurse to serve populations of less than 2,000 persons and to care for the sick in the homes on a visiting nursing plan" (p. 26). He believed that public health nurses should provide nursing care to families within a specific population group.

The primary role of nursing in the provision of nursing care for "the people" was supported more recently by Dr. Halfdan Mahler, the former director general of the WHO. He predicted that nurses' roles would become more focused on the community, more innovative, entail greater responsibility, and would involve more program planning and legislation (Mahler, 1985). The Pew Health Professions Commission advocated for a change in focus of health professionals from "organ specific physical illness" to a new vision of caring for the community through health promotion (O'Neill, 1993).

Much of the confusion over the terms in the nursing care of communities began prior to the mid 1980s when community health nursing referred to nursing care in essentially any location out of a hospital or nursing home (Baldwin, Conger, Abegglen, & Hill, 1998). Curricula in community health nursing were developed in the 1950s and 1960s with encouragement from the National League for Nursing (NLN) to integrate

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concepts formerly taught in schools of public health. The National League for Nursing (NLN) suggested that the term community health be used as an umbrella for nursing services practiced in community settings (Flynn, 1985). The focus was on care of the individual and family in their homes consistent with the definition of nursing care in the community (Flynn, 1985). In a more limited definition, the focus of care of public health nursing was governmental and often focused on vulnerable populations. Interestingly, the Medical Subject Heading (MeSH) for "community health nursing" in the OVID database included the following "scope note":

> Scope: General and comprehensive nursing practice directed to individuals, families, or groups as it related to and contributes to the health of a population. This is not an official program of a Public Health Department.
>
> NOTE: SPEC qual; do not confuse with PUBLIC HEALTH NURSING (a government function) (OVID, 2000-2003).

In 1985, a Consensus Conference on the Essentials of Public Health Nursing Practice and Education (U.S. Department of Health and Human Services, 1985a) was held to redefine the terms. Again, community was defined as location of practice and community health nursing was supported as the term for any community based practice setting. The Consensus Conference defined public health nursing in terms of specialized education, not location. About ten years later, the Public Health Nursing Section of the American Public Health Association (1996) agreed with this earlier definition by stating that "public health nursing is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (p.1). This definition provides little information about the function of public health nursing or a

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description of the practice. The lack of clarity between the functions and roles of public health and community health nurses is also evident in community health nursing textbooks (M. J. Clark, 1999b; Clemen-Stone, McGuire, & Eigsti, 1998b; Smith & Maurer, 1995; Stanhope & Lancaster, 2000). Stanhope and Lancaster (2000) address the duality by entitling their latest edition *Community & Public Health Nursing*. They specifically differentiate categories of community nursing practice as community-oriented, public health, community health, and community-based (p. 1). These definitions all overlap in some way and merit further clarification.

The confusion over the functions of community and public health nursing practice was strengthened with the publishing of the report *The Future of Public* Health by the Institute of Medicine (1988). With the description of the core functions of public health as assessment, policy development, and assurance, rather than provision of health care, many public health nurses who were providing care to families in community settings, found they had to redefine their practice (Baldwin, Conger, Abegglen, & Hill, 1998). Health departments across the United States began to refocus their energies away from direct services. Nurses began to speak of the concepts of "community as client" and "population based care." Baldwin, Conger, Abegglen, and Hill (1998) argued that the defining characteristic of "community/public health nursing" (and they describe the practice as both in the article) is population based care. Stanhope and Lancaster (2000) defined public health nursing as a component of community health nursing writing that the focus of a public health nurse is on the population as a whole, working with the community to improve the population's health status (p. 11). It can be argued that this is also the role of "community health nurses." Unfortunately, the conceptual confusion

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continued in the 1990s, as managed care organizations and hospital systems also began to describe the health care provided to their panel of clients as "population based."

There continues to be a lack of consensus over the view that "community" is a legitimate phenomenological focus for and of nursing (Sills & Goeppinger, 1985) and conceptual confusion over its relationship to public health (Quad Council of Public Health Nursing Organizations, 2000; White, 1982). It has been argued that nursing practice defined by setting can be considered community nursing. The questions become: when should the practice be titled "community health" or "public health" nursing and what is population focused care?

Community Health and Medicine

Many physicians practicing in the public health arena view the community through an epidemiological lens and in this discipline the term "public health" is used more often to describe concepts related to the health of the community. Physicians more often use epidemiology as evidence for health care activities that can be applied to populations ("Assessing health concerns and priorities", 2000; Flynn, Rider, & Ray, 1991; Koplan, 1999; Turnock, 2001). There has been more recent discussion of the need to expand the philosophical foundations of the discipline to include "the role of systems theory in conceptualizing the nature of epidemiological studies" (Weed, 1999, p. 103). The expansion into behavioral science by public health experts in the United States would bring the discussion closer to the philosophical views entertained by international or sociological experts in community health.

The conceptual confusion about community health in medicine is evident in the use of the terms preventive medicine, primary health care, community oriented primary

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care, public health and more recently population health. Kark (1981) believed community medicine was part of the larger field of public health. Describing the inclusion of community oriented functions in the developing roles of the family physician in the United States and the general practitioner in the United Kingdom in the late 1970s and 1980s, he wrote: "At the same time, community medicine has developed in these countries. In my view, it is an important area of the older and broader field of public health, a discipline which extends beyond community medicine and personal health care to the environmental sciences and engineering" (p.vii). He further defined public health as:

> . . .one of the major elements of social action, aimed at modifying the environment and people's behavior in order to promote the health and welfare of society. . . The main objectives of public health practice are to promote health, prevent disease, and ensure the best possible distribution of health and medical care facilities. In placing greater emphasis on its promotive and preventive objectives than on curative care, it stresses the importance of modifying the environment, health-related behavior, and health action by the community. (p. 3)

During this same time period, Florey, Burney, D'Sousa, Serivens, & West (1983) described the confusion over the term "community medicine" and defined it as "a specialty in which medical science (is) applied to groups and populations rather than individuals" (p.1). Others have described the overlap of concepts of "population health" and "health promotion" (Kickbusch, 2003) and Kindig (2003) wrote that the lack of "precision of meaning (in population health) could threaten to render the term more

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confusing than helpful, as may already be the case with 'community health' or 'quality of medical care'" (p. 381).

More recently, Starfield (1996) described the confusion that has occurred over these definitions, roles and functions as the health care delivery system in the United States has changed. She contrasted the private medical care system with the public sector. She defined the role of the medical care system as that of caring for those who sought the services, while the public health care agencies were the "provider of last resort, and the "integrated health systems" as "assuming responsibility for the care of populations" (p.1365). Clinical preventive services were offered by both the private and public systems "largely through opportunity rather than by design." Clearly, as the health care system rapidly changes, the evolution of the concept that concerns the health of communities must be re-evaluated.

Implications for Research

It would seem that the defining characteristics of a healthy community would be evident in the assessment tools used to identify community strengths and challenges. A wide variety of assessment tools are now available for this purpose (Boswell, 1992; Bruce & McKane, 2000; Hospital Research and Educational Trust, 1992). These assessments are often based on epidemiologic strategies that may miss valid contextual information about the community of focus (Primomo, 1995). It is much easier to describe a community problem than to assess a community's strengths and its positive attributes. If health includes social action, such as resilience, empowerment or communication, then instruments must be designed to address these process issues as well as more traditional epidemiological data.

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One of the most difficult challenges in the assessment process is in determining who makes the decisions. McKnight strongly advocates for community members themselves to maintain control over the process of the community assessment and planning ("Assessing health concerns and priorities", 2000). If public health is considered a professional activity, then professionals would decide what to assess, what policies to develop, and what services should be assured. This practice philosophy is in clear opposition to the belief that community members should be in control.

These issues lend support to participatory action research agenda in the study of components of *community health* (Minkler, 2000). In this collaborative process of investigation, researchers coach community members in the research process working together to identify the research questions, the data to be collected, the analysis and the desired action (Hildebrandt, 1996). The purpose is to resolve community issues by building consensus among community members, promoting self reliance within the community (Barnes et al., 1995; Wallerstein, 2000). This type of research is consistent with social models of community health.

The development of concepts is a dynamic process that is an important step in the progress of knowledge development. Evolving concepts reflect the educational backgrounds, research, and theoretical bases of the members of the disciplines that support them. The members of the multiple disciplines including nursing, medicine, public health, sociology, etc. that work in the area of *community health* describe this phenomenon with varying conceptual labels based on the framework of their own disciplines. A systematic analysis of the characteristics underlying the concept as it is described by each discipline is needed to assist those involved in multidisciplinary

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initiatives to better understanding the perspective of the various team members. In this way multidisciplinary education and research concerning *community health* can be promoted. Furthermore, current policy is written without a clear understanding of the concept of *community health*. For example, without a clear definition it is difficult to meet statutory mandates requiring assessments of the "health" of a community. Without a clear definition of what characteristics comprise a "healthy community," the concept of *community health* will be operationalized from the disciplinary view of each researcher. Using ambiguous definitions to set community health priorities has critical implications when constituents demand resource allocations based on priorities. A clear definition is needed to better describe the method for developing the priorities.

The analysis proposed for this study will provide more conceptual clarity about the concept of *community health* through a systematic examination of the characteristics ascribed to it by members of the disciplines of medicine, public health, nursing, and sociology. A description of the scope and breadth of the definition and the uses and meaning of the concept will help to build a new "interdisciplinary" theoretical model and enhanced understanding of the concept among the members of the many disciplines who engage in the practice, research, and education of *community health*.

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Chapter Three: Method

The focus of this chapter is on the design and methods used to study the concept of *community health.* Rodgers' (2000) Evolutionary View of Concept Development was chosen as a model for the design because the dynamic nature of concepts is acknowledged and because rigorous sample selection procedures are integrated into qualitative research methods. The processes and rationale for the sample selection, procedures for protecting human subjects, collection of data within the three phases of the study, and data analysis are all included in this chapter.

Purpose and Rationale

The need for the development of clear concepts has been supported by researchers and philosophers since the Greek philosophers, e.g. Aristotle's early taxonomic rules for classifying phenomena. With a call for greater use of electronic means of data collection and analysis of information in health (U.S. Department of Health and Human Services Press Office, 2005), the need for clarity among the data elements collected is even more necessary. Norris (1982) stated, "when concepts are clarified precisely, their influence is powerful" (p.13). By precisely naming phenomena, we are better able to describe and build knowledge concerning them. Furthermore, we would expect that as the world and science evolve, names and attributes of concepts would change to better match their evolving applications. This seems to be true when defining the concept of *community health.* "Public health," "community health," "population health," even "sanitary hygiene" are terms that have addressed similar phenomena at different times. The purpose of this research is to better understand the concept of *community health* in order

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to further build knowledge of this concept. An understanding of the attributes and the use of concept will support this effort.

As researchers have supported the need for clear concepts, they have also developed various methods for clarifying them. Early efforts in concept development were more positivistic, with methods designed to reduce the concept to its essential qualities. Aristotle described the need to identify the essential nature of an entity, a viewpoint now known as essentialism (Mautner, 1997; Rodgers, 1991). In essentialism, the focus of the inquiry is to identify those attributes that comprise the essence of a concept, differentiating it from other concepts by identifying those attributes that are necessary and sufficient to describe the phenomenon it represents. In viewing these attributes as "essential," there is an inherent risk that the meaning of the concept becomes fixed and thus does not evolve with changes in context or with time (Rodgers, 1991). Wilson applied this philosophy as he developed a method that when applied to research, required the investigator to develop borderline and contrary cases to outline the boundaries of the concept being described (Avant & Abbott, 2000; Wilson, 1963). These methods did not account for the sociocultural context of the application of the concept and/or its evolution over time.

Other philosophers have discussed the development of scientific knowledge from a historicist standpoint (Kuhn, 1996; Laudan, 1978; Toulmin, 1972). Laudan described changes in knowledge development as the process of problem solving in a discipline, while Kuhn described the major paradigm shifts in a discipline as "revolutionary." In contrast to the essentialist viewpoint in which carefully controlled, empirical results are the outcome, historicists view science as a process that occurs within a sociocultural and

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environmental context. With this view, the mistakes made in scientific problem solving and the context that surrounded the problem solving process yield important information about the outcomes.

The historicist, Toulmin, described the conditions that a scientific enterprise must meet to be described as a discipline, the means of enculturating new members, and the processes used to explain scientific goals. He identified those scientific "enterprises" that have achieved "disciplinary" status as those whose "conceptual repertory is exposed at every stage to critical reappraisal by qualified judges" (p. 378). The interdisciplinary nature of *community health* makes this critical appraisal process more difficult. Who determines a "qualified judge"? What is the process for the "critical appraisal"? He also contrasted the evolution of the physical sciences with social sciences: "During the last 100 years, conceptual developing in the physical sciences has displayed some striking changes of direction; yet, taken overall, it has nevertheless been progressive and cumulative. . .In the sciences of collective human behavior, the pattern has been very different. Instead of being progressive or cumulative, theoretical development has gone through a series of pendulum swings" (pp. 384-385). In regards to conceptual development in less developed disciplines (or those of "collective human behavior"), he described both methodological and institutional issues:

> In the former case (methodological), their shortcomings spring primarily from the absence of a clearly defined, generally agreed upon reservoir of disciplinary problems, so that conceptual innovations within them face no consistent critical tests and lack any continuing rational direction. In the latter case, the deficiencies spring primarily from the absence of a suitable professional organization, so that

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> the disciplinary possibilities of the subject are not fully exploited, and the rational purposes of its practitioners are frustrated. (p. 380)

As community/public health is interdisciplinary, the development of community health is more complex. Each participating discipline must communicate not only within its own members but across the disciplines. The pendulum swings in community health may be associated with historical and sociocultural periods surrounding various health policies and funding (community mental health vs. the war on drugs) and initiatives (healthy cities movement and community oriented primary care). Although the American Public Health Association (APHA) serves as the professional organization for "public health," there is no professional organization for "community health." The membership of the APHA includes nurses, physicians, biologists, epidemiologists, sociologists and others who identify themselves as doing public health work. Yet each is doing this work within their own disciplines and the process of identifying a "clearly defined, generally agreed reservoir of disciplinary problems" (p. 380) in an interdisciplinary context may be, if not more difficult, at least more complex. The definitions of *community health* used by various professional and nonprofessional groups indicate these conceptual difficulties.

The need for careful explication of the changes in concepts over time has been advocated. In writing about the history of scientific development, Kuhn (1962) stated that the role of the "science" historian is to fully describe each newly discovered scientific outcome or process including the errors involved in the process of its discovery. Toulmin (1972) also articulated the need for adequate descriptions of the context surrounding a discovery. By studying the history of science a "bigger picture" appears in which the dynamic changes in a discipline can be seen over time, often in a nonlinear process. The

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importance of the historical and socio/cultural context to an understanding of a concept's development becomes more evident. This "bigger picture" can be seen in the development of the disease now known as AIDS (Acquired Immune Deficiency Syndrome). Bowker and Star (1999) described the evolution of the nomenclature surrounding this disease through the history of the virology, public health, and changes in standardized forms and classifications used by insurance companies and the U.S. Census Bureau. The separate histories that evolved in each of these varied groups led to difficult, if not devastating outcomes for those identified with the disease in its early years. Until the nomenclature was described similarly by all of these groups, different groups adopted varying policies and practices concerning those with the illness. For example, Bowker and Starr wrote that when an "attempt was made to combine these data (public health, virology, U. S. Census Bureau) in the 1980s to disenfranchise young men living in San Francisco from health insurance, the resultant political challenge stopped the combination of these data from so being used" (2002, p. 44). A more systematic process for developing conceptual definitions is necessary for the careful explication of these ideas that includes not only the views of the scientists studying the concept, but the historical and social context surrounding these definitions. As concepts form the foundational language of a discipline, scientific progress can often be observed in the language of that discipline. Science is dynamic and with time and use, the meaning of its varying concepts will change. Research methods that are employed must document this dynamism. The descriptions in the literature of *community health* have changed through the years. In documenting the evolution of this concept, it is important that the methods used to describe the concept adequately take into account the surrounding context. Based on this

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philosophy, the analysis of the concept of *community health* will be conducted using Rodgers' Evolutionary Method of Concept Analysis (2000, 1993). This method provides for a systematic selection of the sources of data containing the conceptual attributes and the sociocultural context surrounding its use. It is expected that the results of the analysis will provide a better description of the concept of *community health* so that academicians and researchers can expand current research and theoretical models related to it. Toulmin (1972) observed that "concepts acquire a meaning through serving the relevant human purpose in actual practical cases" (p. 168). A more explicit description of the concept of *community health* will serve as a foundation for future problem solving relevant to community health research and practice.

A variety of approaches have been developed to identify the elements of a concept. In *Thinking with Concepts*, Wilson (1963) described a method of concept analysis that has been used as a starting point for many nurse researchers. Using his model, Walker and Avant (1994) identified three approaches to the process of concept development including analysis, synthesis, and derivation. In a summary of the specific steps in concept development, Meleis (1997) integrated the process of concept exploration as an initial step. Chinn and Kramer (1991)included the process of concept clarification in which broader sources of data are used in the process of developing meaning. Knafl and Deatrick (2000) described the process of concept analysis as: "synthesizing existing views of a concept and distinguishing it from other concepts for the purpose of attaining the state of the art of the subject area" (p. 39). Rodgers (2000, 1989) addressed the evolutionary nature of concepts and also developed a more systematic process for the analysis. In her refined method, she acknowledged the

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limitations of the Wilsonian approach and recommended more rigorous sampling of documents or other articles for analysis (providing for a broader array of data to be included) and a more systematic data collection technique that includes uses of the concept and the context surrounding the use. She described the process as "breaking apart of a thing to identify its constituent components" (p.83).

Rodgers (2000) described the specific activities to be completed using this evolutionary method of concept analysis. These activities are not linear and often occur simultaneously as the concept is identified and described.

1. Identify the concept of interest and associated expressions (including surrogate terms).
2. Identify and select an appropriate realm (setting and sample) for data collection.
3. Collect data relevant to identify:
    a. The attributes of the concept; and
    b. The contextual basis of the concept, including interdisciplinary, socio-cultural, and temporal (antecedent and consequential occurrences) variations.
4. Analyze data regarding the above characteristics of the concept.
5. Identify an exemplar of the concept, if appropriate.
6. Identify implications, hypotheses, and implications for further development of the concept. (p. 85)

The first five steps of Rodgers' Evolutionary Method will serve as the framework for the first of three phases identified as the methodology for this study. These form the activities involved in Phase I, the analysis of the professional literature and the

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development of an exemplar. In addition to this phase, two other phases are added to test the proposed exemplar of the concept of *community health.* In Phase II, the exemplar is tested against community health assessment instruments. In Phase III, the exemplar is further tested by analyzing the perceptions of key representatives working in the field of community health. The sixth step in Rodgers' model will be applied throughout the processes of the study identifying implications and directions for future research. The three phases of the study are described in Figure 1 and more completely in the following sections.

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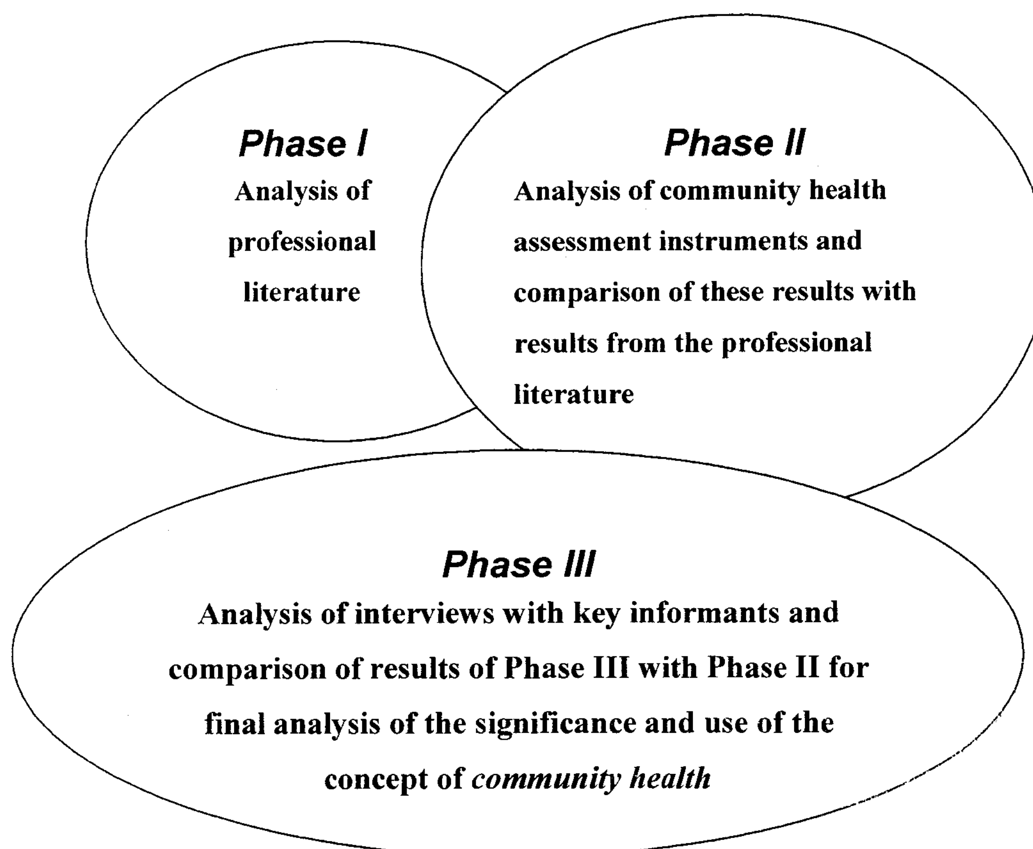
Figure 1. Method used for the analysis of the concept of *community health*



*Adapted from Rodgers, 1993b and Sadler, 1995.

Phase I: Analysis of the Sample of Professional Literature

In the initial phase of this study, the various definitions and uses of the concept of *community health* by members of various disciplines were explored and analyzed through a sample of articles published in the professional literature. Meleis (1997) described the need for concept exploration in two cases: when a new concept is introduced into the literature or when a concept is so familiar that its definition is taken for granted. In this case, the use of the term "community health" became more evident in the literature in the 1980s and has now become so commonly used that the meaning has become unclear and

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often confused with the term "public health" and other concepts such as "primary health care" and "population health."

After several sessions with a reference librarian whose expertise relates to health and science literature and a professor of information science who teaches classification systems, the databases of MEDLINE, CINAHL, Academic Search Elite, and Sociology Abstracts were selected to represent the most citations for the disciplines of study: nursing, medicine, public health, sociology, and urban studies. Anthropological Literature also was used in the initial selection of the article population, but was not included in the final data set because the majority of the articles in this domain were related to the culture of health practices (Frankenberg, 1980) and the study of humans, particularly in primitive cultures (Mautner, 1997). To limit the dataset, a population of articles was then selected using key words/combinations that offered the best potential for deriving the characteristics and attributes of the concept of *community health* without eliciting a population of articles that was too large to be managed by the researcher. This procedure was developed in consultation with the reference librarian by trying various combinations of key words and databases. For example, an early trial included using all of the initially selected combinations of key words elicited a total of 13,389 articles for 1990-2003, the period of study Deleting the citations from Anthropological Literature (23) and those identified through the use of the key words: community and primary health care (2,544), community/health assessment (76), and community and health promotion (2,884) and community health assessment (76) reduced the initial dataset to 7,862 citations. The dataset was further limited by selecting key words from only titles of the citations and deleting the duplicates found between databases. During the initial exploration of the

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concept, it became clear that the concept was often interchanged with public health. For this reason, "public health" was also used as a key word.

The final list of key words used to select the citations included:

- Community health
- Community and public health
- Community health nursing
- Community health and definitions
- Public health and definitions
- Community and public health.

The final population of articles in each database was as follows: Sociological Abstracts® (n=54), CINAHL® (n=52), Medline® (n=348) and Academic Search Elite® (n=1231) for a total of 1685. The citations were downloaded into separate files in Endnote® Version 7, a bibliographic software program and a hard copy of the results was printed. To identify the sample, each citation was numbered and a random selection of citations was identified using a random numbers table for each database. The sample was selected based on the inclusion of a minimum number of 30 citations per database and a representative percentage of the total number of articles in the data set (Cinahl 3% or 30 articles, Sociological Abstracts 3.2% or 32, Medline (20.6% or 106, and Academic Search Elite 73% or 369).

The selected databases were chosen to best elicit citations that represented the disciplines of nursing, public health, medicine, sociology. There is considerable overlap of the disciplines of authors in each database. For example, many nurses and public health professionals submit articles for publication in journals listed in Medline© and all

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of the disciplines included in the study submit articles for inclusion in journals listed in Academic Search Elite©. For this reason, a set of rules was established for determining the discipline of the author reflected in the literature source. "Discipline" was determined first by the database, second by first author of the article, and third by the journal. For example, if the author was a physician with a Master's in Public Health and the article was published in the *American Journal of Public Health,* the article was considered in the discipline of public health. If the journal was the *Journal of Preventive Medicine*, it was categorized as an article in the discipline of medicine.

Upon completion of the identification of the background of the authors, the articles were coded according to the categories requisite for the Rodgers' Evolutionary Model of Concept Analysis (2000) including:

- Attributes, ie. characteristics, such as those found in definitions;
- Socio-cultural context of the use of the concept including the "antecedents" or situations that precede an occurrence of the concept; "consequences" or events that may follow the occurrence of the concept; and/or the "significance" of the concept in serving the promotion of the concept in actual practical cases;
- Referent situations in which the concept is used, and
- Related or associated concepts. (Adapted from Kersbergen, A. L. 1996 and Sadler, J. J., 1995, See Coding Form in Appendix A)

Notes were typed for each article and organized according to the above coding scheme using a bibliographic software program (Endnotes®, Version 9). Most of the noted text was transcribed exactly as it occurred on the pages of the publication. Page numbers for each text block were noted for easier retrieval of broader content areas or for

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review of the original source of data during analysis. As the articles and books were analyzed and noted, an annotated bibliography was drawn from the notes and printed in an RTF (Rich Text Format) file. These files were then entered into a software program, NVIVO 2©, used for analysis of qualitative data. NVIVO 2© was used in addition to Endnote® because it allows for more detailed qualitative analysis than the bibliographic software. These notes were then entered into a software program used for qualitative research (NVIVO, Version 2). The set of notes for each reference was coded in two ways: for the themes cited in the study questions and then inductively coded for more specific themes. Each line of notes was reread and lines and blocks of text were coded.

The next step in the process included analysis of text within the annotated bibliographic data. The information collected from each source was reread and coded according to the research questions and through an inductive process. Researchers vary in their use of coding schemes (Ryan & Bernard, 2000). In classical content analysis there is an assumption that the codes are already devised (Ryan & Bernard, 2000). In this study the text was initially coded as it related to the first two research questions concerning the definitional attributes of the concept, the socio-cultural context in which it is used, and any related concepts and their overlapping definitions. The literature source was also coded for the discipline of the first author and whether the source was from the United States or a country outside of the United States. This coding category was determined to help identify the sociocultural setting for the literature source. Secondly, the text was coded using a more inductive process to identify major substantive themes. The theme of each section of text was labeled inductively as each source was analyzed.

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These themes were later aggregated to identify major thematic categories. Rodgers (2000) described this stage of the data analysis:

> As the data are organized and appropriate "labels" are identified to describe the major aspects of the concept, analysis takes on a more theoretical focus. The researcher may examine the data for areas of agreement and disagreement across disciplines, change over time, or for insight into emerging trends concerning the concept. (p. 95)

As varying terms were used interchangeably with *community* health, they were identified as a related concept or surrogate term in the notes. The number of occurrences in which each of these terms was used was noted in resulting NVIVO 2© reports.

Reports were then generated using the qualitative software program that included all text from citations related to the attributes, socio-cultural context, referent situations, and related concepts for the entire sample and then separately for each discipline. The analysis of these reports is included in the following chapter.

Because of the volume of literature sources in the population regarding the concept of community health and the procedures used for indexing the sources of data, there was a risk of missing important sources of information through the random selection of literature in the databases. For that reason, a list of landmark/classic works was solicited from a panel of experts (Rodgers, 2000). After the sample of citations from the professional literature was developed, a letter was mailed to five community health professionals to solicit their ideas regarding landmark/classic works in the area of community health. These individuals included those who have directed state or national community health projects and/or authored major works in community health. Permission

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was granted by the University of Wisconsin-Milwaukee Institutional Review Board for the Protection of Human Subjects to contact these individuals and for the interviews conducted in Phase III. It was expected that these individuals would have a strong grasp of the literature in this area and would provide additional ideas regarding the literature sources to be included in the sample. Based on the responses of these experts, additional citations were added to the sample which was analyzed after the initial sample was completed. Four of the five professionals responded to either a first or second inquiry. The initial letter is included in Appendix B. An additional list of 36 citations were identified, analyzed for the study questions and entered into ENDNOTE® and NVIVO 2©. Notes from these articles and books were coded using the same process as that used for the random sample of professional literature. This included coding the text for the research questions and for inductive themes.

Reports regarding the first two research questions were then retrieved from NVIVO 2© for each research question for the literature sample as a whole and the separately for each discipline. These questions included:

1. What are the predominant attributes of the concept of *community health* as presented in the professional literature of each discipline included in the study?
2. What is the context, socio-cultural and temporal, surrounding the evolution of the concept of *community health* as presented in the literature?

After the 305 articles were analyzed, it was noted that no new themes had emerged from the data for about 90 articles. At that point, the sample was analyzed to determine the degree of representation of the disciplines of interest: nursing, medicine, public health, sociology, and urban planning. It was found that it was difficult to discern "urban

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planners" as a separate discipline and this area was not included in the final analysis. At that point, the sample each of the remaining disciplines were represented in the literature with at least 30 articles, the minimum needed for each stratum.

After completion of the analysis of the literature retrieved, an exemplar of the concept of community health was developed. Rodgers (2000) stated that: "The purpose of an exemplar is to provide a practical demonstration of the concept in a relevant context" (p. 96). In this research, the exemplar took the form of a definition derived from the attributes of the concept. It is expected that the model definition is "generic or universal enough to illustrate the concept clearly" (Rodgers, 2000, p. 96) and may be applied to a variety of situations. With the philosophical belief that concepts evolve, this model definition provides an exemplar of the concept of *community health* derived from literature primarily published between 1990 and 2003, with an expectation that it will change as it is applied to future *community health* situations. It is hoped that this model and the sociocultural context from which it was derived will serve as a foundation for future development of the concept.

Phase II: Analysis of Community Health Assessment Instruments

The second phase of this study included an analysis of community health assessment instruments to identify attributes of *community health* that are included in data collected and processes used for assessments of "communities." This phase was conducted to address the third research question: How do the attributes of the concept of community health presented in the literature compare with variables identified in instruments designed to assess a community's health?

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The community health assessment instruments selected for analysis were 1) tools that have been used nationwide in the United States and that were suggested by the experts in their lists of landmark works; 2) one state department of public health community health assessment instrument; and 3) one used by local public health agencies. The national instruments included the Institute of Medicine's "Community Health Improvement Process" (CHIP) (Institute of Medicine, 1997), Mobilizing for Action through Planning and Partnerships (MAPP) (National Association of County & City Health Officers, 2001), and the Community Toolbox (Fawcett, 1998). The statewide instrument selected for the study was the Illinois Project for Local Assessment of Needs (IPLAN) (Illinois Department of Public Health) and this was included in the list of landmark works. The "Community Health Needs and Utilization Survey" (Lundeen, 1992) was published in the professional literature and was used for local communities. The instruments used nationally were developed by three different organizations (Centers for Disease Control and Prevention, Institute of Medicine, and the National Association of County and City Health Officials) for use mostly by official public health agencies and are largely based on epidemiologic models of data collection. The Community Health Improvement Process is used not only for local assessments but as a structure for performance monitoring of statewide and local public health agencies. The IPLAN developed and used by the Illinois Department of Public Health is a very extensive instrument that is also used throughout the state of Illinois for local assessments and monitoring the performance of the local health departments in its jurisdiction. The Community Toolbox is a different model in that the instrument promotes community engagement and is more focused on the process of the assessment than the specific

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outcome measures. The Community Health Needs and Utilization Survey is based on a data collection model developed for nursing that includes assessing the environment, physiological and psychosocial issues, and health related behaviors. This survey instrument is designed to collect information about participant perceptions of health issues and is to be used in coordination with local epidemiologic data.

These six instruments were analyzed to identify and compare the key variables that are used for the assessment of the health status of local communities. The materials accompanying each instrument were read and organized to identify the attributes of community health underlying the conceptualization of the instruments. The instrument itself was considered an example of the use of the concept. After the coding and analysis of the community health assessment instruments, the data were compared with the attributes and exemplar identified in Phase I. A comparison of the articles in the sample published at the time of the development of each instrument also provided information about the socio-cultural context that shaped the various community assessment instruments (Kincheloe, 2000). For example, the PATCH, CHIP Model and MAPP were developed and revised over a period extending from the early 1980s through the early 2000s. Although the literature sample did not extend into the 1980s, the historical trends and sociocultural context identified in the literature from the early 1990s provided some information about the conceptualization of community health as it was exemplified in these instruments.

Phases III: Testing of the Exemplar within the Community

This final phase was conducted to test the exemplar derived in Phase I. This phase addressed the fourth research question: How do the attributes and context of

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community health as presented in the literature and in variables included in assessment instruments compare with beliefs of key informants, including community health leaders and persons practicing in community health? The final phase included analysis of seven interviews with professional community health leaders/experts who had lead major initiatives in community health and/or had published books/articles about community health planning or policy. They were chosen to represent the disciplines of concern in the study: nursing, medicine, public health, and sociology. While attending community health conferences over the past two years, the researcher discussed the opportunity for participation in the study with eligible, potential participants. In most cases, these professionals were the keynote speakers. If interested, the participant was re-contacted when the first two phases of the study were completed. A letter (email) requesting participation was sent to those who had been approached face to face. In one case, the expert was contacted through a snowball approach in which another researcher suggested the name of the expert and, in a final case, the expert had written textbooks concerning community health. The group of experts included two lawyers (one involved in public health law and one in international communicable disease control), two Registered Nurses (one with a Ph.D. in sociology), two physicians and one professor of human growth and development who has been involved in social initiatives in community health. All of these individuals worked in community health arenas (practice, education, and/or research) at the time of the data collection.

With the participant's informed consent, the interviews were audio-taped, transcribed, and entered into NVIVO® Version 2. These data also were coded and analyzed according to the study questions. The progression of each phase of the study

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was illustrated previously in Figure 1. In two cases, the participants referred to articles they had written that further described their views of community health. These articles were also analyzed to confirm and/or expand their views of *community health*. In this last phase of the derivation of the concept, the results of Phase II were compared with Phase III for a final analysis of the significance and use of the concept of *community health.*

Trustworthiness

The purpose of any research design is to expand elements of knowledge. In a qualitative or naturalistic inquiry, there is no expectation that the researcher can control the design in a manner that allows for prediction, yet the researcher hopes that a new level of understanding may be reached. Determining "the definitive answer to what the concept is" (Rodgers, 2000, p. 97) is not an expectation for the results of an analysis of a concept according to the approach used in this study. "Instead, the aim is to provide the foundation and clarity necessary to enhance the continuing cycle of concept development" (Rodgers, 2000), p. 97. Rather than attempting control and prediction, in a qualitative design the research can be evaluated with regard to its "trustworthiness. Trustworthiness, in this study, refers to whether the researcher actually captured the meanings within and surrounding the concept being studied. (Olesen, 2000). Olesen wrote that those who:

> . . .believe that there are ways of achieving validity that reflect the nature of qualitative work will seek out ways to establish credibility as through such strategies as audit trails and member "validation," techniques that reflect their postpositivist views but that do not involve hard-and-fast criteria for according "authenticity" (2000, p. 230).

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The elements of trustworthiness described for qualitative research endeavors were used to support the design of this study. Lincoln and Guba (1985) addressed "trustworthiness" in their set of Axioms establishing a rubric for qualitative research. In Axiom 3: The possibility of generalization, they wrote, "The aim of inquiry is to develop an idiographic body of knowledge in the form of working hypotheses that describe the individual case (p.38). Although, hypotheses are not specifically used in naturalistic inquiry, a set of working attributes were developed during the analysis of the content. For example, as part of the inductive process of coding, the researcher thought about the connections between themes as coded sections of text were categorized into larger groups of content surrounding the concept of *community health.*

This multiple phased design is consistent with Lincoln and Guba's (1985) axiom that the nature of reality (ontology) can only be studied holistically. They wrote that ". . . inquiry into these multiple realities will diverge . . . so that prediction and control are unlikely outcomes although some level of understanding *(verstehen)* can be achieved" (p. 37). Using four sources of data: the sample of professional literature, the landmark works, community health assessment instruments, and key informant interviews provides "multiple realities" supporting a greater degree of rigor or "trustworthiness" in the data collection and less opportunity for researcher bias as the data analysis is tested in each phase of the study. The elements of trustworthiness include truth value, applicability, consistency, and neutrality (Krefting, 1991; Lincoln & Guba, 1985). Each of these are described as they apply to concept analysis in the following section.

Lincoln and Guba (1985) described the process of developing trustworthiness by answering four questions related to the establishment of (1) truth value, (2) applicability,

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(3) consistency, and (4) neutrality. The truth value refers to the credibility of the study. During the analysis of a concept, there may be a variety of beliefs regarding the definition of the concept. It is up to the researcher to capture these multiple realities. In this study, there were several methods for enhancing the truth value. By seeking data from a range of databases, there was a greater potential for data that described the use of the concept in various contexts. The use of a rigorously developed sample of literature representing multiple disciplines supported "multiple realities" or disciplinary views that have influenced such a broad concept. The randomized selection of the sample articles adds more strength to the design in Phase I in that the researcher has less influence on the selection of the data sources (citations in the literature). The process of audiotaping and carefully transcribing the interviews of the key informants was done to best capture the experiences of these experts with the concept of *community health*. Furthermore the use of multiple methods to compare and confirm the working attributes in each phase of this study, helped to promote the trustworthiness by establishing the "truth value," or "some confidence" (p. 290) in the findings. The comparison of the key informants' perceptions of the attributes of and sociocultural context surrounding *community health* and their experiences with its use with the findings from the professional literature sample and the community assessment instruments in the third phase of the study enhanced the "truth value."

The applicability of a study (or external validity) refers to the ability to apply the findings to another population or situation (Krefting, 1991). In qualitative inquiry this applicability is addressed by the researcher providing enough information about the process to repeat the study in another setting or with a different population group

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(Lincoln & Guba, 1985). The careful delineation of the research process in this study supports its applicability. Sandelowski (1986) described applicability as "when there is confidence that selection biases, effects of pretesting subjects, effects of being in a study, and multitreatment effects have not produced conditions that are incomparable to conditions in the natural world" (p. 31). She further wrote that it was the responsibility of the researcher to "establish the typicality" of the data (p. 31). In this study, the random selection of the literature sample reduced the opportunity for selection bias. The use of nationally recognized community health assessment tools coming from different disciplines supported the "typicality" of the instruments and the use of experts from differing disciplines as key informants also supported to some extent the "typicality" of the interviews.

The consistency of the study also supports applicability in that the methods must be clearly delineated. Consistency refers to whether the findings would be replicated using the same methods (Krefting, 1991). The consistency of the study was supported by selecting the sample of literature and instruments from readily available and commonly used database indexes and by randomly selecting the literature sources. Using the methodology described for Phases 1, 2 and 3, another researcher should be able to replicate the steps of this study. The consistency is supported through the use of multiple methods and the review of the methods by members of the research team (committee members) so that the trustworthiness of the study is enhanced. The "auditability" of the study is also a means of supporting its consistency (Rodgers & Cowles, 1993; Sandelowski, 1986). In qualitative research, an audit trail can enhance this "auditability." For this reason, a log was kept during the study of all decisions about the research

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methods and thoughts or "field notes" about the research process. This log was kept through all phases of the study and initially served to document the processes of determining key words, disciplines to include in the study, potential databases, discussions with the reference librarian and professor of informatics. During the data collection phase, it was used to document thoughts of the researcher as she read and analyzed articles. These included thoughts of study limitations such as potential biases in the sample selection. In later phases of data analysis, the thoughts of the researcher related to connections between sections of text and clustering of attributes were described. The log served as a potential trail for auditing the research process by other researchers who would be able to examine and evaluate the rationale for the sampling, data collection procedures, and analyses and whether the outcomes and conclusions are well linked to these processes.

The last criterion, neutrality, is "confirmed" when "auditability, truth value, and applicability are established' (Sandelowski, 1986). In his book, *Thinking with Concepts*, Wilson (1963) cautioned that the derivation of meaning is dependent upon the view of the analyst. Lincoln and Guba (1985) ask "how one can establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer" (p. 290). In determining the definition of a concept, the perspective of the researcher must be taken into account as the data are selected, coded and analyzed. In this study, neutrality was established through the random selection of the sample articles, the request for landmark/classic works, the analysis of readily available community health assessment instruments, and the use of an audit log. The random selection of the literature increased

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the neutrality of the researcher by eliminating the selection bias. By asking key informants for classical and landmark studies to review, the researcher again had less influence on the sample. Reviewing the data with seven key informants helped to address the biases of the informants themselves. The convergence of their ideas with the results from the literature and instrument analyses also supports the neutrality of the study. The analysis of the variables in the instruments provided additional data in that it allowed for cross checking of health indicators across instruments. The community health assessment instruments selected were those used by national/statewide and/or public groups offering more opportunities for scrutiny by both users and respondents. The ongoing notes kept in the audit trail log are vital to the assessment of the neutrality of the principal investigator (Knafl & Deatrick, 2000). This ongoing evaluation of the design and results provided opportunities for assessment of the perspectives and biases of the researcher. A final test of the neutrality and the overall trustworthiness of the study will be completed upon publishing results of the study in a journal with a juried review.

Limitations

This study, as with all research, has some limitations including potential bias in the indexing of the literature, the determination of the discipline of the authors, the sampling techniques and the selection of key words, community health assessment instruments, and key informants. There was a potential bias in the choices of databases selected to identify the population of literature that best represents the concept of *community health.* The databases were used to elicit the professional literature sample because in their use of the key words "community health," the databases provided evidence of the institutionalization of concept.

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Work with a reference librarian whose expertise is health information helped to reduce this limitation. The researcher also reviewed the types of literature included in the various databases to ensure that the appropriate journals would be included in the sample. For example, at first review it was felt that the journals included in CINAHL would be mostly included in MEDLINE. After discussion with the reference librarian, it was determined that CINAHL includes more international nursing literature and as this information had the potential to be important to the sociocultural context of the study, it was included in the study.

A second limitation was in the selection of the disciplines of the authors cited in the study. Bias could have been introduced through the process of determining the disciplines of study and through the processes of determining the discipline of the author. The initial exploration of the concept prior to the analysis of the concept in this study served in part to identify those disciplines most likely to have published literature concerning *community health.* These included sociology, urban planning, nursing, medicine, and anthropology. During the sample selection and data analysis, the selection of the disciplines of study was further refined by omitting sources from anthropology and urban planning. As described earlier, the field of anthropology was determined to be related more to humans and their cultures and was excluded from the sample. While coding the literature sources, it was found that it was difficult to determine whether an author had a background in urban planning and for this reason, articles were not coded according to this criteria. This process points out the potential bias of mislabeling the discipline accorded to a study when using the first author's background and the

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publication. The bias may have been reduced by the volume of literature that is reviewed and the consistent application of criteria for decisionmaking

Bias may also have been introduced during the selection of the sample of literature. The initial search for the key words "community health" using one of the larger indexes revealed a list of 39,791 citations. With a body of literature of this scope, it is impossible to completely review the literature concerning the concept. The random selection of the sample was intended to enhance the potential for drawing a representative list of citations that reflected the literature about the concept of *community health.*

Finally, the background of the researcher may have influenced the data analysis process. This limitation was addressed by keeping an audit trail of both the decisions made by the researcher and field notes of thoughts about the data collection and analysis process during the research. In this way, there was a greater potential for the researcher to continually assess the credibility of the analytic process while coding and categorizing clusters of attributes.

Summary

Laudan (1977) observed that "the increase in conceptual clarity . . .through careful clarifications and specifications is one of the most important ways that science progresses" (p. 50). Currently, there is considerable confusion associated with the concept of "community health." Rodgers (1989) articulated "when the definition, or attributes, of a concept are not clear, the ability of the concept to assist in fundamental tasks is greatly impaired" (p. 330). A major task for researchers includes facilitation of clear communication among other researchers, academicians, and practitioners. The systematic analysis of the concepts that comprise a discipline helps to increase the clarity

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of scientific communication. With this clarification, individuals are better able to define the use and application of the concepts of their disciplines. A systematic analysis of the concept of *community health* will assist community groups who are defining the health of their communities by defining a core set of attributes. Furthermore, dissemination of a clear definition would assist communities in collaboration and coordination of their assessment efforts.

Although in recent years there has been more attention to the issue of concept development, there has been little attention to the specific research methods used for the analyses (Avant & Abbott, 2000). Silva (1999) and Im and Meleis (1999) described the need for new research techniques that are context specific and non linear. Using the evolutionary method of concept analysis assures that the context surrounding the definition and its application is described. Upon completion of the analysis in this proposed study, it is hoped that community health professionals and community members will better understand the meaning of "community health" and its use in specific situations.

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Chapter Four: Results

The data for this research were collected in three phases using the Rodgers Evolutionary Method of Concept Analysis. In Phase I a random sample of literature was analyzed to identify the attributes of the concept of *community health*, the socio-cultural context surrounding its evolution, and to identify similar and related concepts. The literature for this sample was selected from the following electronic databases: Medline (OVID version), CINAHL, Academic Search Elite, and Sociological Abstracts to provide a selection of professional literature representing the disciplines of nursing, public health, medicine, sociology, and urban studies from the years 1990 to 2003.

A sample of "landmark works" identified by key informants was also analyzed during Phase I. A group of key informants/experts were asked to identify a list of classic/landmark works in community health to ensure that important documents relating to *community health* were also included in the sample. These will be described more completely in the following sections. Phase II included an analysis of community health assessment instruments to identify the variables commonly used to describe a community's health and to compare these with the key attributes and the model definition identified in Phase I. Phase III included semi-structured interviews with leaders/experts in community health. The purpose of these interviews was to compare the attributes and the model definition identified in Phases I and II with the ideas of key informants about the concept of *community health.* Data from these interviews were used to refine the analysis completed for the previous two phases and to extend the analysis with empirical observations from key informants.

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Phase I Literature Sample

Description of the Sample

The first phase of the analysis focused on a sample of literature that was selected to represent the population of literature concerning *community health* that was published in professional journals, books, and electronic media between the years of 1990 and 2003. Using literature searches in CINAHL, MEDLINE, Academic Search Elite, and Sociological Abstracts, the researcher identified all of the publications indexed using the key words (and combinations of key words): community health, community and public health, community health nursing, community health and definitions, public health and definitions, community and public health. This resulted in a population of 1685 sources of literature. A random sample of these publications was selected to represent the disciplines of nursing, public health, medicine, sociology, and urban studies with a resulting sample of 560 publications.

In addition, the researcher wrote to authors/experts who had written extensively in the area of public and community health and requested a list of what each considered to be "essential reading" that they felt best represented classic or landmark publications regarding the concept of *community health.* Four of five of the experts responded and provided an additional list of 36 publications. The fifth expert responded and indicated that she did not have sufficient time to identify the resources. The list of publications included 23 books, 8 electronic sources/reports and 2 articles from professional journals and three instruments. The instruments were included in the analysis of community health assessment instruments in Phase 2.

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Each publication was read and coded according to the discipline of the author and the geographic area referenced in the article (e.g., United States or international). The background of the author was determined first by the database, second by the author and third by the journal. In most cases in the literature sample, sociologists were designated as such if they were associated with a university department of sociology or if theydescribed themselves as a sociologist. Social workers were included with the category of sociologists. It was difficult to differentiate between urban planners and sociologists, so urban planning was not included in the final analysis of the data. The background of the author was identified in 94.1% of the sample. The disciplines were represented in the literatures sources as 24.59% public health, 29.18% nursing, 20.66% medicine, and 16.07% sociology and social work.

Upon the completion of the coding of 305 (54.5%) articles, the sample was analyzed to determine whether it provided an adequate representation of the disciplines of the authors. There was a minimum of 48 articles in each category of discipline. In addition, it was determined that the saturation point for additional themes had been reached as only one new theme had been identified in the previous 90 references. The analysis of each of the study questions and the analysis of the themes that emerged from the coding began at that time.

The landmark works were then analyzed using the same method to determine whether similar or additional themes were found in the coded text of landmark works. The list of "landmark works" is included as Appendix D. Finding that no additional categories were added to the code list, the researcher continued to read additional articles in the sample during the analysis phase to identify textual content that might better

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illustrate or provide additional perspective to the description of the identified themes and to ensure that all relevant themes were identified.

Major findings from Phase I Data Collection

Analysis of data obtained from the randomized sample of professional literature and the classic/landmark works addressed the following research questions for the first phase of the study.

1. What are the predominant attributes of the concept of *community health* presented in the professional literature of nursing, public health, medicine, and sociology?
2. What is the socio-cultural context, including its common use, surrounding situations, and antecedents and consequences of its use, surrounding the evolution of the concept of *community health* as presented in the professional literature?

A list of 169 themes was developed through the inductive coding process. These were categorized into broader major themes related to the major study questions and additional categories derived from the inductive analysis. The major thematic categories and their component themes are listed in Appendix E. These served to identify the attributes of the concept of *community health* that formed the exemplar definition. The themes also served to inform the sociocultural context that surrounded the use of the concept.

The definition of *community health* developed from the data is: *Community health* is a dynamic condition defined by its members through participatory action in partnership with professionals of disciplines identified by the community members and based on philosophical beliefs of community development and empowerment. Its focus is on health promotion and disease prevention for the entire population using an ecological

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model of health improvement and including broad determinants of health. This definition was derived from attributes identified in the analysis of the professional literature. These attributes included "participatory action," "diverse and interdisciplinary partners," "philosophical beliefs of community development and empowerment," "population based," "a focus on health promotion and disease prevention and broad determinants of health," and "use of ecological models or frameworks for health improvement."

The concept of *community health* in its dynamism and continuous evolution is different from the "state" of being a "healthy community." The "condition" of community health evolves and is defined for each community by its members through locally developed community health assessment processes. Based on the needs of each community, *community health* is defined differently.

The sociocultural context in which *community health* occurs is rooted in beliefs of social justice, yet takes place in a global economy in which wide disparities in wealth are evident and in which governments have fewer resources for community development and health improvement. This context was identified from categories of literature that concerned social justice, economic models of health care, fewer resources in government and health care, and increasing health and social disparities among population groups. The use of the concept of *community health* was also influenced by a series of initiatives and reports by major public/community health organizations. For example, many of the authors of the professional literature referred to World Health Organization documents that defined "health" and "primary health care" in supporting community development and promoted "health for all by 2000." These articles supported community development models of health improvement in which local communities are involved in defining their

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health and health improvement strategies. These and other initiatives and documents will be described more completely later in this paper.

Both "population health" and "public health" are used as surrogate terms for *community health.* Surrogate terms are "means of expressing the concept other than the word or expression selected by the researcher" and are differentiated from related concepts in that surrogate terms share the same attributes as the focus of the study (Rodgers, 2000). In many cases, "public health" and "population health" are used interchangeably with *community health.* Related concepts provide for more of the surrounding context of the concept within the knowledge base in which it is used. In the professional literature sample and the landmark works, a variety of concepts were found to be related to *community health.* These included community, health, primary health care, community development (which was also an attribute). These surrogate terms, related concepts, the attributes of *community health* and the sociocultural context surrounding its use will all be described in more detail in the following sections.

Summary of Phase 1

Research Question 1: What are the predominant attributes of the concept of *community health* presented in the professional literature of nursing, public health, medicine, and sociology?

Rodgers (2000) described the attributes of a concept as constituting: "a *real* definition, as opposed to a *nominal* definition that merely substitutes one synonymous expression for another" (p.91). Regarding the process of seeking the attributes or characteristics of the concept, she further wrote: "The author often has to work diligently to identify data relevant to the attributes of the concept. . . authors rarely provide such

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definitions in their writing" (p. 91). Thus each article was carefully analyzed to identify statements that would best characterize the concept of *community health*. In most cases, exact excerpts of the text were coded and examples of each attribute were evident in both the literature sample and the landmark works.

Community Health: A Dynamic Condition Defined By Its Members through Participatory Action

One of the most common themes in the literature sample was that of community participation in community health planning and implementation (Aubry & Tefft, 1995; Buschkens, 1990; Conway, Hu, & Harrington, 1997; Flynn, Rider, & Ray, 1991; Gibbon & Cazottes, 2001; Iwami & Petchey, 2002; Johnson, 2000; Kalnins, 2001; Parks & Straker, 1996; Plough & Olafson, 1994; Puertas & Schlesser, 2001; Robinson, 1999; Rosenau, 1994; Schmid, Kanenda, Ahluwalia, & Kouletio, 2001; Sherraden & Wallace, 1992; Shrestha, 2003; Truman & Raine, 2002; Tsutsumi, Tsutsumi, Kayaba, & Igarashi, 1998) and research (N. M. Clark, 1999; Couto, 2000; Delacollette, Van der Stuyft, & Molima, 1996; Fisher, 1999; Flynn, Rider, & Ray, 1991; Gibbon & Cazottes, 2001; Glick, 1999; Gough, Chambers, & Jones, 1997; Kemp, 2003; Ledogar, Acosta, & Penchaszadeh, 1999; Lubben & Damron-Rodriguez, 2003; Morrow, 2000; Rosenheck, 2000; Schwab & Syme, 1997; Shrestha, 2003; Truman & Raine, 2002; Tunzi & Croughan-Minihane, 1999; Williams & Yanoshik, 2001). Fawcett (1998)defined *community health* as "a form of living democracy: people working together to address what matters to them." (3. A healthy community, ¶ 1) McMurray (1999) supported Fawcett's participatory action view of *community health.* She wrote, "Community health is created by people working collaboratively to shape and develop their community in a

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way that will allow them to achieve positive health outcomes, (p. 3) These examples provide evidence for community based participation in health improvement efforts as an attribute of the concept of *community health.*

Rosenau (1994) outlined many of the issues in participatory action when she contrasted modern with postmodern views of community organizing for community health. She described a continuum in which the principles of participation (vs. representation), the dynamism of communities (vs. excessive individualism), intertextuality (vs. causality) in research, and the development of local leadership (vs. use of outside experts) support a post modern view that is philosophically closer to the participatory action model.

The problems associated with representation were often included in the professional literature. Representation refers to the ability of individuals to "re-present" or speak for other individuals or groups. This was evident in reports of representation of minority and underrepresented groups (Campbell & McLean, 2003; Couto, 2000; Secker & Hill, 2002; Serrano, 2003). For example, in selecting members of underrepresented groups from community organizations, Campbell (2003) stated:

> Caution needs to be exercised in assuming that the membership of such groups and networks will automatically serve to identify representatives who are qualified to articulate the needs and interests of their minority ethnic group across dimensions such as age, gender, educational levels and language skills. (p. 260)

Allen (1997) wrote about the underlying philosophy of representation and participation in her description of the WAND (Women and Development Unit) program in Barbados:

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> . . . is rooted firstly in the Unit's understanding that human beings are inherently powerful, co-operative and possess the answers to the problems which confront them. Therefore in designing its programmes WAND acknowledges that the experience of the human being is an extremely valuable basis from which ideas for development should be formulated. Secondly, WAND believes that human behaviour which does not manifest power could be attributed to the constraints imposed on the human being as a result of his/her experiences in interacting with society's structures. Development programmes should therefore involve people in the analysis of these structures--race, class, gender and international relations as starting points in any process of change (p. 7).

The participatory action principles also were applied to community health research. In an often cited article, Israel and colleagues (1998) described community based, participatory research as involving "a cyclical and iterative process" in which all parties are equally involved in decision-making for:

> . . .partnership development and maintenance, community assessment, problem definition, development of research methodology, data collection and analysis, interpretation of data, determination of action and policy implications, dissemination of results, action taking (as appropriate), specification of learning, and establishment of mechanisms for sustainability." (p. 180).

Thus, in a participatory action approach, the community members own and direct the activities that constitute *community health*.

This view supports the interdisciplinary nature of the concept of *community health* in that no one disciplinary field can address broad community health issues or

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activities (Buschkens, 1990; Cashman, Anderson, Weisbuch, Schwarz, & Fulmer, 1999; Gebbie, Rosenstock, & Hernandez, 2003; Kemp, 2003; Kneipp, 2000; Pittman, Wold, Wilson, Huff, & Williams, 2000; Yu & Godfrey, 2000). These authors described the need to include biostatisticians, planners, epidemiologists, economists, social workers, therapists, psychologists, physicians, nurses, sociologists, urban planners, and lawyers. The collaboration of these professionals with community members was described in the literature as a "partnership" model (Brunner, 2001; Campbell & McLean, 2003; Cashman, Anderson, Weisbuch, Schwarz, & Fulmer, 1999; Chambers, 1991; Citrin, 2001; Clarke, 1999; Drevdahl, 1999; Green & Mercer, 2001; Hall-Long, Perez, & Allbright, 2001; Meade & Calvo, 2001; National Association of County & City Health Officers, 2001; Northridge, 2003; Payne, 1998; Plough & Olafson, 1994; Richards, 2001; Ritchie, 2001; Schlaff, 1991). For example, a citation in the literature sample included:

> The essence of a community-based model was described as the development of partnerships between the provider and the recipient of care, and continuous two-way communication between the parties, that takes place in settings where individuals and groups live, work, and interact, including tertiary care settings. (Staats, 2003), pp. 95-96

If a community based, participatory approach requires community ownership of the processes of problem solving in community development, education and research, then it is up to the community members to define the needed consultants for the *community health* work. Levine (1994) described these processes:

> Essential characteristics of this partnership include community-based leadership and ownership of specific programs, training and utilization of indigenous

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community health workers, joint planning for sequenced strategies to address various problems in a culturally sensitive and competent manner, interdisciplinary community practice and training opportunities for faculty and students, and prospective planning for and evaluation of long-term maintenance of effective strategies.(p.

These views also were supported in the landmark works (Clarke, 1999; Fawcett, 1998; Gebbie, Rosenstock, & Hernandez, 2003; Institute of Medicine, 2003; National Association of County & City Health Officers; Peterson & Alexander, 2001; Weissman, 1996). For example, Ranson (2002)wrote about the World Health Organization's application of community participation in its goal of "health for all":

> (The) Declaration of Alma Ata implied that community participation was integral to the achievement of health for all. . .that primary health care requires and promotes maximum community and individual self reliance and participation. . .making fullest use of local, national, and other available and other resources. (p. 613)

Gebbie (2003) wrote that "Public health professionals in the 21st century must understand the major concepts and principles underlying community-based research to engage more effectively in research and practice activities" (p. 93). All of these references described collaboration/partnerships between the professional and nonprofessional members of the action teams in re 309) gard to the concept of *community health.*

Using Rosenau's (1994) postmodern reference, a more "postmodern" approach would require greater ownership of community health activities by members of the

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community. On a postmodern – modern continuum, more professional input into the decision making would reflect a more "modern" view. The literature supports the belief that local leaders can better set the priorities to address the issues confronted by local communities and the widening disparities in wealth and health outcomes. Consistent with the attribute of empowerment, a key role in community health is the development of leadership for local communities. The World Health Organization Declaration of Alma-Ata in 1978 included a definition of primary health care in which community involvement was a prerequisite and local leadership development was supported. Many authors in both the literature sample and landmark works supported the idea that each community defines its own priorities for improving the quality of life and supporting local leaders in this effort. (Becnel, 2001; Couto, 2000; Elliott, Taylor, Cameron, & Schabas, 1998; Emanoil, 2000; Flynn, Rider, & Ray, 1991; Israel, Schulz, Parker, & Becker, 1998; Ledogar, Acosta, & Penchaszadeh, 1999; Michielutte & Beal, 1990; Monekosso, 1993; Reininger, Dinh-Zarr, Sinicrope, & Martin, 1999; Shrestha, 2003; Yip, 2001) (Fawcett, 1998; Weissman, 1996). Since Alma Ata, community control over health development processes have strengthened, yet a tension exists over how much "control" over the processes the community should have.

Schwaband and Syme (1997) described this tension, although their reference to "service" also supports a more modern (and somewhat elitist) role of the professional:

> This collaboration is not easy. It calls for cross disciplinary patience, as well as cultural sensitivity and competence, to overcome the differences of race, class, and age that generally exist between public health specialists and populations we are here to serve. (p. 2050)

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This tension is also evident in the context of "user involvement," again a more "modern" view in that the ownership of the project remains with the professionals. Truman and Raine (2002) described the need for structures to support participatory action through greater "user involvement:"

> User involvement models should be seen to be more democratic and less hierarchical in their organization, with clear policies and established structures for users to influence the 'making and creating' of the services they receive. User involvement may also be seen as a means of enabling service users to regain a sense of control over events, and increase their ability to make constructive choices and decisions. (p. 139-140)

The use of data in community health assessment and resource allocation points to the need for involvement of professionals with epidemiological expertise. This also may enhance the tension that may exist between professionals and community members. Again, this tension is evident in the following samples of text. McDowell (1987) described the need for a research based model for describing health, while Billingham (1991) left more of the decision-making to the members of the community. As McDowell (1987)reported:

> There is no single variable that describes health; instead, its measurement relies on assembling a number of variables as indicators of health, each of which represents an element of the overall concept. (p. 11)

In contrast, Billingham (1991) wrote:

> We must base our service on needs, not just professionally defined needs but the needs felt and expressed by individuals, groups and communities ... Collecting

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> information is a complex activity and needs to be local if it is to inform practice. (p. 42)

Other authors described the opportunities for health improvement through epidemiological research as 1) "the health effects of the many components of an socio-environmental approach to health" are studied (Baum, 1995), (p. 419); 2) "hypotheses generated from surveillance will lead to work on prevention of such incidents and protection of the public health" ((Bowen et al., 2000), (p. 872); and, 3) the "actual causes of death in the United States are found in the way the nation allocates its social resources and shapes its program emphases"(McGinnis & Foege, 1993), (p. 2211) McMurray (1999) described the roles of the professional and community members in enhancing health improvement in this way: "Decisionmaking in health matters flows from indigenous leadership generated from within the community in the context of ecological exchange. Professionals are enablers, facilitators, and professional expertise is a resource." (p. 3) She further wrote: "The health professional adopts a role as *advocate* rather than decisionmaker, encouraging *indigenous leadership* wherein decisions originate from local individuals (McMurray, 1999, p. 12). Mooney (2000b) summarized these issues within the context of policy development:

> We cannot continue to have policy initiatives driven by levels of evidence that are based on the priorities that researchers and funders have determined for themselves. (p. 112)

In summary, there was strong evidence that the concept of *community health* entails community participation in collaboration with professionals. Authors who

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presented the concept this way also indicated that the greater the collaboration, the greater investment and ownership the community has in the process.

In addition to the need for an interdisciplinary array of professionals, many authors in the literature sample promoted the need for these professionals to be culturally competent. This was a very consistent theme in the literature sample (Allen, 1997; Baum, 1995; DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001; Eshlemann & Davidhizar, 2000; Finlay, Duckett, & Eliatamby, 1995; Flanagan & Zaferatos, 2000; Gibbon & Cazottes, 2001; Hynes, Brugge, Watts, & Lally, 2000; Jack Jr. & Airhihenbuwa, 1993; Jensen & Bowman, 2002; Kemper, Spitler, Williams, & Rainey, 1999; Leipert & Reutter, 1998; Mcmunn, Mwanje, Paine, & Pozniak, 1998; Monekosso, 1993; Mykhalovskiy & McCoy, 2002; Nguyen, Kagawa-Singer, Tanjasiri, & Foo, 2003; Puertas & Schlesser, 2001; Ransom, 1993; Ritchie, 2001; Schulte, 2000; Secker & Hill, 2002; Taha & Merghani, 1990; Truman & Raine, 2002; Turnbull, Hannigan, & Champney-Smith, 1999; Warshaw, Gugenheim, Moroney, & Barnes, 2003; Yip, 2001). Many authors in the literature sample specifically supported a need for more professional education about culture and competency (Anonymous, 2000; Chen, Ervin, Kim, & Vonderheid, 1999; Kemp, 2003; Mykhalovskiy & McCoy, 2002; Schulte, 2000; Truman & Raine, 2002). In referring to public health professional education, the Institute of Medicine Committee on Educating Public Health Professionals for the 21st Century wrote: "Cultural competency must emerge from the category of 'necessary nuisance' that it too often occupies, which both isolates and trivializes its role. Cultural competency should be supported as an essential element in teaching, research, and practice" (Gebbie, Rosenstock, & Hernandez, 2003) (p. 84). The underlying theme of these references is

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that participatory action in *community* health is enhanced when providers are "culturally competent." When culturally competent, professionals are better able to communicate their knowledge and expertise to community members, thus providing these members opportunities for more informed decision making. Furthermore, improved communication between professionals and community members supports community development and empowerment. Both of these philosophical approaches are consistent with participatory action and were attributes of community health derived from the literature that are described below.

Community Development as an Attribute of Community Health

Authors in the professional literature advocated for addressing broad determinants of health in their descriptions of community development (Evans & Stoddart, 1990; Institute of Medicine, 1997, 2003; Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002; Turnock, 2004; Turnock, 2001). These included transportation (Billingham & Perkins, 1997; Weisbrod, Pirie, & Bracht, 1992), education (Betz, 1998; Ferrell, 2002; Hall & Sibthorpe, 2003; Kemper, Spitler, Williams, & Rainey, 1999; Murphy et al., 1996; Ranson, 2002; Sathyamala, Sundharam, & Bhanot, 1992), employment (Beckles, 1996; Betz, 1998; Boutilier, Rajkumar, Poland, Tobin, & Badgley, 2001; Ranson, 2002; Secker et al., 2001; Secker & Hill, 2002), housing (Billingham, 1991; Hall & Sibthorpe, 2003; Secker et al., 2001; Secker & Hill, 2002), access to care (Beckles, 1996; Bunker, Frazier, & Mosteller, 1995; Dillon & Sternas, 1997; Fuchs, 1998; Gabow, Eusert, & Wright, 2003; Getty, Perese, & Knab, 1998; Gusmano, Fairbrother, & Park, 2002; Hall & Sibthorpe, 2003; Lasker, 1997; Mazzuca, Farris, Mendenhall, & Stoupa, 1997; McCann & Clark, 2003; Mishra & Waltzkin, 1995; Plescia, Koontz, & Laurent, 2001; Sathyamala,

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Sundharam, & Bhanot, 1992) and health system development (Truman & Raine, 2002). The text in the literature sample was consistent with that in the landmark works from international (Clarke, 1999) and national organizations (U.S. Department of Health and Human Services, 2000), (Institute of Medicine, 2003, Weissman, 1996 #42) in which a community development approach was supported. Each of these organizations described health from a broad perspective in which health and illness are determined by interrelationships between social and physical environments surrounding populations. For example, the World Health Report (1998) included a reference to this broad community development approach: "The "city summit" in Istanbul in 1996 outlined new directions for human settlements that would "ensure satisfaction of the social, economic and environmental goals of sustainable development" (p. 123). An often cited source that addressed "broad determinants of health" in their "health field model" was included as one of the landmark works (Evans & Stoddart, 1990) Beyond the "individual response related to biology and behavior, the determinants of health in the "health field" model include: the social environment, the physical environment, and genetic endowment (Evans & Stoddart, 1990). The perspective that the health of populations is promoted through a broad array of "determinants" (e.g. housing, transportation, education, access to are, etc.) supports community development as an attribute of *community health.*

Empowerment as an Attribute of Community Health

Empowerment was also an attribute of *community health* described in the professional literature. Kemp (2003) wrote: "Education in community and other aspects of nursing, medicine, and related fields should be about how to heal the sick, prevent illness, promote wellness, and empower people to gain greater control over their lives and

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health" (p. 145). This theme was echoed through the literature sample (Baum, 1995; Becnel, 2001; Billingham, 1991; Campbell & McLean, 2003; Cheadle et al., 1998; Dewar, White, Posade, & Dillon, 2003; Gibbon & Cazottes, 2001; Glick, 1999; Gough, Chambers, & Jones, 1997; Johnson, 2000; Light, 1997; Mykhalovskiy & McCoy, 2002; Oreiro, 1995; Parks & Straker, 1996; Plough & Olafson, 1994; Rafael, 2000; Reeve, Cornell, D'Costa, Janzen, & Ochocka, 2002; Ritchie, 2001; Rosenau, 1994; Sherraden & Wallace, 1992; Shrestha, 2003; White & Whelan, 2003) and in several of the landmark works (Fawcett, 1998; Institute of Medicine, 2003; Wolfson, 2002; World Health Organization, 1998). Philosophically, empowerment is consistent with the attributes of participatory action and community development in *community health.* Shrestha described the link between participatory action research (PAR) and empowerment in building family planning skills in women in Nepal: This empowerment model describes three distinct PAR cycles in developing competence and confidence among the FCHVs (female community health volunteers) [...] The first cycle of the model is concerned with the enhancement of the skills of individual FCHVs in implementing the strategies planned for increasing contraceptive acceptance among the CMWRAs (currently married women of reproductive age). [...] The second cycle, the reinforcement cycle is concerned with developing confidence of FCHVs in implementing the strategies planned for increasing contraceptive acceptance among the CMWRAs...the third cycle: the self-reliance cycle... is carried out by FCHVs individually with the CMWRAs in their respective communities (Shrestha, 2003), p. 324. This example highlights the role empowerment plays in community health improvement and development. When community members build skills that support community health development, they begin

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to take greater control of the planning and implementation of projects that improve the community's health.

Consistent with community development and participatory action, the empowerment of community members requires a partnership between professionals and local community leaders so that community health activities are developed, implemented, and owned at a local level. This developmental approach to empowerment was described as an ongoing process in which:

> It requires changes in both the leadership and orientation of institutions. The term is operationalized through self-determination and community ownership. When applied to a problem like infant mortality, empowerment means that the people themselves who are affected assume key responsibilities for defining, analyzing, and creating problem resolution rather than only relying on externally imposed remedies. (Plough & Olafson, 1994, p. 63)

The characteristics of participatory action, community development and empowerment present in the professional literature all supported the definition of the concept of *community health* as dynamic and defined by members through community based, participatory action. This participatory, community-based view of practice and research underlies the dynamic nature of the concept of *community health* in that community members choose the characteristics of its definition and the issues and problems that confront them. These changes and evolution over time are based on the sociocultural context surrounding them. This interplay will be described more completely in the analysis of the data concerning the sociocultural context surrounding the concept of *community health*. For their part, the professionals must be culturally competent and

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empower community members to make decisions regarding the condition of the health of their communities and the strategies required to develop and improve it. These elements of participatory action and empowerment in the concept of *community health,* common in the literature sample, are summarized by Couto (2000):

> We subscribe to the following values which we believe are consistent with our vision of community health:
>
> - All people have intrinsic value worthy of investment;
> - Cultural diversity is a strength;
> - People have the right of self-determination in their own communities;
> - Mutuality and interdependency is valued over individualism;
> - Participation in the governmental process is a responsibility of a healthy community; and
> - Community education and employment are major preventive health measures. (p. 5)

Based on this analysis, the first part of the definition of *community health* is: *Community health* is a dynamic condition defined by its members through participatory action in partnership with professionals of disciplines identified by the community members and based on philosophical beliefs of community development and empowerment.

A Focus on Populations

Another attribute of *community health* derived from the literature is the focus on aggregates or entire populations (Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002; Kent, Chandler, & Barnes, 2000; Pinner, Rebmann, Schuchat, & Hughes, 2003;

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Thompson, 1995; Yu & Godfrey, 2000). Fawcett (1998) developed the *Community Tool Box* for use in community health planning. He wrote:

> The first step is understanding the context in which people act. By the context, we mean people's experiences, their dreams for a better life, and what makes them do what they do. . . Within this context, people may come together to identify issues that matter to them, such as drug use, job opportunities, decent housing, or crime to give just a few examples. They may then document the health or development of the community with community-level indicators, which are used to measure the extent of problems at the local level. (1. Community context and planning, ¶ 1)

Murray, Saloman, and Mathers (2002) described the focus on populations in the World Health Organization goals for measuring population health: "The first goal, health, is the defining goal for the health system-to improve the health of the population." (p. 4) Billingham and Perkins (1997)wrote about the way that community health nurses address the community differentiating the community health nurse from other nurses:

> It was possible to identify nurses working using a public health approach by the key characteristics that made this work distinct. The nurses are involved in health needs assessment at community or practice population level. They work collaboratively with other agencies and community groups to improve the local environment, for example housing, transport, and road safety, and to increase resources of the local population, for example welfare rights advice, safety equipment, social support networks, child care facilities.. They work with local people using methods drawn from community development, looking out beyond the practice population into the community. (p. 43)

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As Billingham and others have described, the focus on population or aggregate based services is a key characteristic of the concept of *community health.*

A Focus on Health Promotion and Disease Prevention

In addition to participatory action, community development and inclusion of multiple disciplines to solve community health problems, the attributes of *community health* include promoting health and preventing disease within the population or aggregate of focus using ecological models of health improvement. Health promotion and disease prevention activities were common threads through many of the sources in both the landmark works and the literature sample. Historically, disease prevention was a foundational characteristic of public health activities as community leaders attempted to stem the epidemics of diseases such as the plague, cholera, tuberculosis and smallpox (Turnock, 2004). Turnock (2004) highlighted "use of prevention as a key strategy" in a list of "Selected Unique Features of Public Health" (p. 14). He further wrote: "Public health practice incorporates health promotion, specific protection and a good share of early case finding" (p. 92). In the literature sample, there was a call to focus health care services more on health promotion and disease prevention than on tertiary or institutional health care services. McGinnis and Foege (1993) researched the actual causes of death in the United States linking them to risk factors which could be addressed in a more preventive manner. He wrote: The most important implications of this assessment of the actual causes of death in the United States are found in the way the nation allocates its social resources and shapes its program emphases. (p. 2211)

Ongoing surveillance of diseases and health threats is a key form of prevention. In 1951, the World Health Assembly developed what was to become today's

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International Health Regulations which have been expanded to include protection from unsafe drugs and products, working and living conditions, and other issues such as abortion, drug and tobacco use and abuse, and environmental protection. (Clarke, 1999) Disease prevention activities were cited at least 80 times in the literature sample. These activities included screening for a wide array of conditions, e.g., mental health (Brunette, Mercer, Carlson, Rosenberg, & Lewis, 2000; Cort, Attenborough, & Watson, 2001; DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001; Dillon & Sternas, 1997; Glick, 1999; Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002; Shelton, Sager, & Schraeder, 2000), cancer (Dillon & Sternas, 1997; Hale & Bennett, 1997; Levine et al., 1994; Lubben & Damron-Rodriguez, 2003; Nguyen, Kagawa-Singer, Tanjasiri, & Foo, 2003; O'Malley & Mandelblatt, 2003; Phillips & Belcher, 1999; Ratnaike & Chinner, 1992; Sox, Dietrich, Goldman, & Provost, 1999; Weisbrod, Pirie, & Bracht, 1992), substance abuse (DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001; Dillon & Sternas, 1997; Droege, 1995; Emanoil, 2000; Flynn, Rider, & Ray, 1991; Humphreys & Rappaport, 1993; Jameson, 2003; Mishra & Waltzkin, 1995; Morrisey, Ridgely, Goldman, & Bartko, 1994; Murphy, Gass-Sternas, & Knight, 1995; Reininger, Dinh-Zarr, Sinicrope, & Martin, 1999; Warshaw, Gugenheim, Moroney, & Barnes, 2003) and cardiovascular disease (Billingham, 1991; Carande-Kulis et al., 2000; Dillon & Sternas, 1997; Hale & Bennett, 1997; Weisbrod, Pirie, & Bracht, 1992).

In addition to screening, prevention activities included providing health education about various behaviors and diseases, such as cardiovascular disease (Buschkens, 1990; Elliott, Taylor, Cameron, & Schabas, 1998; Imamura, 2002), medication management (Butz & Malveaux, 1994; Cort, Attenborough, & Watson, 2001; Getty, Perese, & Knab,

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1998; Hale & Bennett, 1997; Murphy, Gass-Sternas, & Knight, 1995), and information about caring for family members (Jordan, Hardy, & Coleman, 1999; Kirk, 1999; Long & Baxter, 2001; McCann & Clark, 2003; Moules & Chandler, 1999; Salt, 2003; Secker et al., 2001). Health education activities also were provided to promote and maintain health among populations of well individuals and families. These were offered through a variety of activities including one to one education for individuals and group classes (Harvey, 2001; Miskelly, 1995; Ransom, 1993; Samuels & Sommer, 1997; Weisbrod, Pirie, & Bracht, 1992), health fairs (Dillon & Sternas, 1997; Phillips & Belcher, 1999; Weisbrod, Pirie, & Bracht, 1992) and use of the media (Droege, 1995; Elliott, Taylor, Cameron, & Schabas, 1998; Hynes, Brugge, Watts, & Lally, 2000; Mcmunn, Mwanje, Paine, & Pozniak, 1998; Mishra & Waltzkin, 1995; Phillips & Belcher, 1999; Poole, 1997). The breadth of literature in the sample and in the landmark works provides evidence of that health promotion and disease prevention are key attributes of community health.

Ecological Models of Health Improvement

The promotion of healthy environments through ecological models of health improvement is also an attribute of the concept of *community health.* This is evident in both the focus on environmental assessment and improvement and in a call for use of ecological models and frameworks in community health. For example, the environment is often cited as a content area for community assessments (Beckles, 1996; Billingham, 1991; Eshlemann & Davidhizar, 2000; Faruque, Lofton, Doddato, & Mangum, 2003; Finlay, Duckett, & Eliatamby, 1995; Gerberich, Stearns, & Dowd, 1995; Hagland, 1997; Johnson, 2000; Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002; Ruth, Eliason, &

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Schultz, 1992; Stanley & Stein, 1998; Tunzi & Croughan-Minihane, 1999). Although discussion of ecological models often was focused on water quality and sanitation in developing countries (Buschkens, 1990; Ferrell, 2002; Gibbon & Cazottes, 2001; Hall & Sibthorpe, 2003; Puertas & Schlesser, 2001; Sathyamala, Sundharam, & Bhanot, 1992), it also is an important attribute of *community health* in urban settings (Carruth, Cormier, & Gilmore, 2002; Couser, Moehrlin, Deitrich, & Hess, 1990; Emanoil, 2000; Faruque, Lofton, Doddato, & Mangum, 2003; Grealis, 1997; Johnson, 2000; Kuo & Torres-Gil, 2001; Kurowski, 1991; Mazzuca, Farris, Mendenhall, & Stoupa, 1997; Parks & Straker, 1996; Roper & Mays, 1999; Tunzi & Croughan-Minihane, 1999) as the impact of health concerns such as lead based paint, asthma risks, and other environmental hazards affect health in built communities. Both qualitatively and quantitatively, the data in the literature sample supported the functions of health promotion, disease prevention, and promotion of healthy environments as key attributes of the concept of *community health.*

The interconnectedness of individuals with their environments promoted in ecological frameworks is also evident in this attribute. These relationships are described in both the literature sample and landmark works (Baum, 1989; N. M. Clark, 1999; Flynn, Rider, & Ray, 1991; Gebbie, Rosenstock, & Hernandez, 2003; Hall & Sibthorpe, 2003; Institute of Medicine, 2003; Israel, Schulz, Parker, & Becker, 1998; Johnson, 2000; McMurray, 1999; Mishra & Waltzkin, 1995; Piko, 2004; Tsutsumi, Tsutsumi, Kayaba, & Igarashi, 1998). The holistic perspective of *community health* that is based on broad determinants of health supports this framework. As the Institute of Medicine .(Institute of Medicine, 2003)described it,

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> Environment in this case denotes the broad context of health, which includes elements of the natural (e.g., air and water), built (e.g., houses, parks, and roads), social (e.g., connectedness and social capital), economic (e.g., income and employment), and political environments. (p. 25)

In a later Institute of Medicine report regarding the education of public health professionals, Gebbie et al. (2003) wrote:

> The committee believes that public health professionals must understand this ecological model. They must look beyond the biological risk factors that affect health and seek to also understand the impact on health of environmental, social and behavioral factors. They must be aware of how these multiple factors interact in order to evaluate the effectiveness of their interventions. They must understand the theoretical underpinnings of the ecological model in order to develop research that further explicates the pathways and interrelationships of the multiple determinants of health. (p. 7)

Ecological models explain interrelationships at intrapersonal, interpersonal, organizational, community and public policy levels and are similar to traditional epidemiologic models of host-agent-environment (Poole, 1997, p. 167). By linking this interconnectedness to Nightingale's work, Rafael (2000) described a historical precedent for use of ecological models in both nursing and public health by describing Nightingale's focus on "the importance of the environment on healing" (p. 39). Rafael further wrote:

> The interconnectedness of all things do not stop with human interactions but extend to issues that are critical to the health, healing, and survival of the earth

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> and all life on it, revealing an ecologic aspect to her (Nightingale's) theory. (p. 39)

More current references reflect the need to apply ecological models to epidemiology (Schwab & Syme, 1997), health promotion (Elliott, Taylor, Cameron, & Schabas, 1998) and community health improvement (Durch, Bailey, & Stoto, 1997). In applying an ecological model to epidemiology, Schwab questioned:

> What does an ecological and participatory paradigm imply for epidemiology? It implies working across disciplines, and with the population itself, in defining variables, designing instruments, and collecting data (qualitative and quantitative) that reflect the ecological reality of life in that population, as people experience it. (Schwab & Syme, 1997), p. 2050)

Elliot further described the interconnectedness of health promotion with ecological models in health improvement within a larger framework of systems theory, stating that "A systems theory framework for an ecological approach to health promotion informs the conceptualization of the key constructs" (p. 608). He also described the links between health improvement and the environment, "improvements in the health status of the population at large, or of particular subgroups, are seen to depend on changes in the environments which both promote and sustain health related behaviour" (Elliott, Taylor, Cameron, & Schabas, 1998, p. 609).

These references define the associations between health promotion, healthy environments, and community health improvement within a framework of ecological models. They provide evidence for the inclusion of health promotion, disease prevention,

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and healthy environments through ecological models and frameworks as attributes of *community health.*

There were no clear patterns between the disciplines of nursing, medicine, sociology, and public health among the attributes. There was more emphasis on epidemiology among the authors whose backgrounds were in public health and/or medicine than sociology and nursing. Yet nurses and sociologists also supported the issue of epidemiological data in program planning and policy development. This would be consistent with the more biomedical views of medicine and public health and a more psycho-social view among many nurses and sociologists or social workers. On the other hand, as will be described in the description of the findings in Phases II and III, there is growing support for "community involvement" in community health planning and development among more traditional "governmental" public health practitioners.

Scope of the Concept

As the researcher reviewed descriptions of the content and services provided in *community health* in the citations in the sample, a listing of the array of topics related to the content was compiled. This listing was developed to provide both a quantitative and qualitative perspective of the scope of the concept of *community health.* Table 1includes this list of the cited services/content and the number of times these topics were included in the sample of literature. Most of these topics would be the content of health promotion and disease prevention activities as characteristics of *community health.* The data in this table supports the breadth of the concept of *community health* as it is used in programs and services. It also provides evidence of the many uses of community health as part of the "socio-cultural" context in which it has evolved. The consistency of the scope and

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specific areas of focus lend additional evidential support for the use of health promotion and disease prevention, promotion of healthy environments (ecological models of health improvement), and community development as attributes of the concept of *community health.*

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Table 1. Scope of *Community Health* by content area and services and number of times cited by authors in literature sample.

Category	Content Area / Services

Health Promotion	Healthy growth and development (n=11) – physical (n=5), mental (n=1), spiritual (n=3)
	• nutrition and food security (n=16)
	  ○ breastfeeding (n=7)
	• exercise (n=10)
	• family planning (n=8)
	• child health (Healthy Start) (n=9)
	  ○ immunizations (n=4)
	  ○ child safety (n=5)
	• senior health (n=9)
	  ○ activities of daily living (n=2)
	• adolescent health (n=6)
	• sexuality (n=5)
	• prenatal (n=5)
	• healthy lifestyles (n=4)
	• dental care (n=3)
	• parenting (n=2)
	• life/stress management (n=1)
	  ○ communication (n=2)

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Category	Content Area / Services
Disease Control and Prevention	Health education regarding prevailing health problems (n=9) • cardiovascular disease knowledge (n=10) • medication management (n=8) • social and behavioral factors (n=6) • family education/caregivers (n=3) • screening (n=12) • injury prevention (n=10) • lead poisoning prevention (n=8) • infant mortality (n=7) • tobacco use and cessation (n=6) • alcohol abuse prevention (n=6) • anger control/violence (n=6) • sexually transmitted disease prevention (n=5) • low birth weight (n=3) • child abuse prevention (n=3) • mental health screening (n=3) • adolescent mental health (n=2) • cancer detection (n=7) • screening for hypertension (n=2) • osteoporosis (n=1)

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Category	Content Area / Services
	• sexual abuse (n=1) • sensory loss (n=1) • disabilities (n=1) • genetic screening (n=1) • assessment of transition readiness (n=1) • arthritis (n=1)
Healthy Environments	• environmental quality of life (n=11) • water quality (n=4) • vehicle safety (n=3) • food handling (n=3) • tobacco enforcement (n=3) • sanitation (n=3) • agricultural methods/hazards (n=3) • recreation (n=2) • restaurants (n=2) • fire prevention (n=1) • moisture and mold (n=1) • crime (n=1) • uncontrolled heating and ventilation (n=1) • occupational hazards (n=1)

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Category	Content Area / Services
Community Development	• reclaiming open spaces (n=1) • chronic mental health services (n=20) • access to health care (n=12) • primary care for vulnerable populations (n=10) • public transport (n=8) • low education levels (n=7) • employment programs (n=6) • housing (n=5) • low status of female population (n=2) • governmental/political interventions (n=1) • health system relationships and knowledge base (n=1) • organizing immigrant rights (n=1) • addressing redlining tactics of local banks (n=1) • child care (n=3) • poverty (n=2)

The scope of the concept of *community health* can also be defined through a developmental approach. Authors described every possible population group from infants (Boutilier, Rajkumar, Poland, Tobin, & Badgley, 2001; Brosco, 1994; Buschkens, 1990; Plough & Olafson, 1994) to the elderly. The World Health Organization (1998) has put a "spotlight on gender" (p. 96). They defined examples of a gendered approach to practice

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in which there is "more consideration of all the factors that affect women's health, not only biological factors but social and economic status, cultural, environmental, familial, occupational and political factors" (p. 96). This approach further supports the attribute of broad determinants of health in defining the concept of *community health.*

Sociocultural Context

In defining the need for exploring the socio-cultural context of the concept being studied, Rodgers (2000) wrote:

> The focus in exploring the contextual aspects of the concept is to gain understanding of the situations in which the concept is used, the use of the concept in those varying situations, and its use by people with potentially diverse perspectives. (p. 91)

She further explained that "identifying the contextual basis of the concept refers to the situational, temporal, and socio-cultural and disciplinary contexts for application of the concept" (Rodgers, 2000, p. 91).

The sociocultural context surrounding *community health* that was derived from the professional literature juxtaposes the roots of social justice with a global economy in which there are wide disparities in health and income and in which there are fewer resources for governments to address community development and health improvement. The current situational/temporal context includes beliefs in smaller government, economic models of health care services, and scarcer resources for community health programs and services. In addition, there have been several initiatives and reports that have shaped the evolving attributes of *community health.* During the past thirty years, the World Health Organization definitions of health, primary health care, and "health for all

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for 2000" and the Healthy Communities/Healthy Cities initiatives have all provided support to a community development approach to health improvement. Furthermore, several of the major professional organizations that address community and public health have addressed some of the nomenclature issues and the work of the discipline. The data that supports this context will be described in the following sections.

Social Justice amid Scarce Resources

The context of a philosophical framework of social justice permeated the sample of literature across all of the disciplines of study and in both the literature written by authors in the United States and internationally. Even within the context of economic models of health care, the principles of equity and distribution of resources for the common good were evident (Clarke, 1999; Cohn, 1998; Couto, 2000; Duff, 1998; Flynn, Rider, & Ray, 1991; Glick, 1999; Harpham, Lusty, & Vaughan, 1988; Kneipp, 2000; Mooney, 2000a; Ong, 2000; Puertas & Schlesser, 2001; Rafael, 2000; Stanton, 2001) In writing about public health, the Institute of Medicine noted the need for a balance between individual liberty and the public good in the United States (Institute of Medicine, 2003) Internationally, many authors supported the need for equitable distribution of resources (Clarke, 1999; Glick, 1999; Harpham, Lusty, & Vaughan, 1988; Monekosso, 1993; Mooney, 2000a; Ong, 2000; Puertas & Schlesser, 2001; Rafael, 2000; Ranson, 2002). For example, Galarneau (an ethicist) and Flynn (a nurse) linked social justice to American traditions:

> These principals and values, including universal access, comprehensive benefits, and fair burdens, are asserted to be deeply anchored in the moral traditions we

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> share as a nation, reflecting our long-standing commitment to equality, justice, liberty, and community. (Galarneau, 2002) (p. 34)
>
> Government is responsible for striving to achieve a balance between the two great concerns in the American public philosophy: individual liberty and free enterprise on the one hand, just and equitable action for the good of the community on the other. (Flynn, Rider, & Ray, 1991), (p. 46)

Clark (also a nurse) (1999) linked the social justice philosophy with primary health care:

> The principles of equity and justice, both assumptions of PHC (primary health care), require that the highest standards of practice and quality of care should exist at all levels of the healthcare system, including community care. (p. 37)

Turnock (a physician) (2001) similarly linked social justice to traditions in public health:

> Social justice argues that public health is properly a public matter and that its results in terms of death, disease, health, and well-being reflect the decisions and actions that a society makes, for good or for ill., (p. 14)

Mooney (2000b) summarized this view from his international public health perspective: "Public health has to be driven by concerns for social justice." (p. 11) These excerpts from the text of both the landmark works and the literature sample provide evidential support for the context of social justice surrounding *community health.*

Unfortunately, a social justice philosophy may be difficult to implement within a context of scarce resources and within economic models of health care. The cost of health care in many countries is increasing, resulting in shrinking funds for community health activities. The literature sample includes examples of this issue in both the United States (Gabow, Eusert, & Wright, 2003; Geis, 1991; Hynes, Brugge, Watts, & Lally,

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2000; Kneipp, 2000; Merzel, 2000; Ong, 2000; Pati, Romero, & Chavkin, 2002; Rohland & Rohrer, 1998; Shelton, Sager, & Schraeder, 2000; Stanley & Stein, 1998; Torrey, 2000; Warshaw, Gugenheim, Moroney, & Barnes, 2003) and the rest of the world (Buschkens, 1990; Harvey, 2001; Mackenzie, 2003; McCann & Clark, 2003; Mykhalovskiy & McCoy, 2002; Ransom, 1993; Ranson, 2002; Robinson, 1999; Stanton, 2001). The shrinking resources are due, in part, to the increased support for individualism that occurred after the 1970s. Allen (1997) described this trend internationally:

> The theme of shifting responsibility away from the State has, however, also been taken up by free market thinkers who wish to `roll back the welfare State' and support an ideology of competitive individualism. Such thinking now pervades Western, and especially right-wing governments and has a major influence in the Third World, particularly via the effects of `Structural Adjustment Programmes' imposed by the International Monetary Fund as a conditionality for financial aid and loans. Thus, whether one is interested in grassroots development or the free market, it is clear that solutions to health problems increasingly need to be found outside the State sector. Furthermore, we must consider that communities may be competing to obtain scarce resources, and therefore pleading special needs. (p. 11)

Several authors described the impact of health policy on the availability of resources. For example, the deinstitutionalization of individuals with mental illness as a result of the Community Mental Health Centers Act of 1963 in the United States led to a growing population in community settings needing increasing mental health therapy and treatment. Unfortunately, although the health care setting was changed, the funding

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needed to support services in community settings never materialized. Werner and Tyler (1993) described the situation:

> Although there was a significant decline in psychiatric hospitalization in state and county facilities, a significant portion of the facilities lacked staff trained to meet the unique needs of this new population of patients and failed to shift care into the community. This started a trend toward repeated brief inpatient stays for many mental health clients. Rather than the deinstitutionalization hoped for, the result was a trans-institutional process that simply moved many individuals from one setting to another. (p. 691)

In another example in Australia, nurses involved in discharge planning were targeted to expand community health services for the elderly post hospital discharge. Robinson (1999) described the surrounding economic environment in rural communities:

> There is a mounting body of evidence which further highlights concerns that aged clients are now discharged from acute hospitals 'quicker and sicker', too early and without appropriate community supports. In rural communities the consequences of these changes are especially severe. (p. 173)

These examples highlight a socio-cultural context across the globe in which there is an increasing emphasis on the provision of health care services with fewer resources and the emphasis on disease oriented care rather than prevention and health promotion. Starr (1982), Evans and Stoddart (1990) and Lee, Benjamin and Weber (1997) described the antecedents and consequences of the emphasis on economic models in which health care vs. "health enhancing activities" is more often supported. Evans & Stoddart (1990) described the affect of economic health care models from a health policy perspective:

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> This concentration of economic effort has meant that public or collective health policy has been predominantly health care policy. The provision of care not only absorbs the lion's share of the physical and intellectual resources which are specifically identified as health-related, it also occupies the centre of the stage when the rest of the community considers what to do about its health. (p. 1347)

This example further highlights the control that health professionals have over the health care delivery system in that "health care" occupies "the centre of the stage." Not only is the rest of the community left "considering what to do about 'its' health," there are few resources left over to use for the projects the community deems should be done.

The economic outcomes were further described in terms of the potential for health improvement and the costs:

> Once we recognize the importance and potential controllability of factors other than health care in both the limitation of disease and the promotion of health, we simultaneously open for explicit consideration the possibility that the direct positive effects of health care on health may be outweighed by its negative effects through its competition for resources with other health enhancing activities. A society which spends so much on health care that it cannot or will not spend adequately on other health-enhancing activities may actually be *reducing* the health of its population through increased health spending. (2001) (p. 1360)

Taking a population focused, health promotion and disease prevention approach would more equitably distribute the funds across the health care delivery system:

> Conservative estimates of the impact of population-based public health strategies aimed at heart disease, stroke, fatal and non-fatal occupational injuries, motor

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> vehicle related injuries, low birth weight, and gunshot wounds alone suggest that 69 billion dollars in medical care expenditure could be averted by the year 2000. (Lee, Benjamin, & Weber, 1997, p. 304)

The literature in the sample and the landmark works included descriptions of these economic issues existing across settings, from the hospital to urban and rural communities regardless of the health concern of the various disciplines. Authors provided much support for the social justice views of community health and supported "social justice amid fewer resources in government and healthcare" as part of the socio-cultural context of the concept of *community health.*

Widening Disparities in Health and Income

Authors of literature in both the random sample and landmark works indicated a widening global gap of wealth that exacerbates the reduction of governmental resources. Even though there is a growing belief that broad determinants support health, the resources available to support health and wellness are not equally distributed and many do not have access to these resources. Ranson (2002) reported the World Bank definition of poverty including the broader determinants of health:

> The World Bank defines poverty as "encompassing not only material deprivation but also low achievements in education and health. In the event of serious illness, the poor are particularly vulnerable to the financial burden of lost income and out-of-pocket medical expenses, as they have low levels of assets necessary to cope." (p. 613)

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In light of the broader determinants of health, Bunker (1995) and Fuchs (1998) described the need for more research about the specific effects of various health promotion/prevention strategies. This passage from Bunker is particularly relevant:

> Today, most observers agree that the causes of increased longevity include, in addition to medical care, improvements in nutrition, housing, sanitation, occupational safety, and lifestyle. If we wish to allocate effort and material resources to achieving further increases in life expectancy, we need to distinguish among these determinants and to estimate the magnitude of their separate effects. (p. 305)

The United States Public Health Service (2000) and World Health Organization (Ong, 2000) have tracked the widening gaps in health between differing population groups and have set goals to address them. "Elimination of disparities" is one of the major goals of the national health plan in the United States and the World Health Organization (WHO) set the goal of "health for all by 2000" in 1977. Attendees of the WHO Conference at Alma Ata described an "imperative for change" as:

> Too few resources were being invested in the health sector, and these were usually spent on meeting the needs of 10-15% of the population. Richer countries had been attracting doctors from the poorer ones – over three-quarters of the world's migrant physicians were to be found in only five countries: Australia, Canada, Germany, the United Kingdom and the United States. Although training of a physician was eight times more expensive than that of a medical auxiliary, many developing countries were still stressing the training of physicians. (World Health Organization, 1998, p. 140)

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In the literature sample, there were many examples of the disparities in health care and other resources (Gabor & Welsh, 1996; Harvey, 2001; Iwami & Petchey, 2002; Jha, 2003; Kent, Chandler, & Barnes, 2000; Mooney, 2000a; Robinson, 1999; Stanton, 2001). In addition to the obvious gap in health status, the gaps lead to other outcomes such as competition for scarce resources (Allen, 1997; Robinson, 1999). Lasker (1997) and Kneipp (2000) described the impact of having fewer health care providers to address community health issues. In recommending greater collaboration between public health and primary care providers, Lasker (1997) wrote: "Through its categorical programs and safety-net service, the public health sector reinforced prevailing policies by accepting responsibility for certain activities that the medical sector had the expertise and training to perform but had little incentive or interest to do" (p. 20). Kneipp (2000) described the same workforce disparity issues as they apply to community health nursing:

> In countries such as the United States, where postindustrial capitalism is the basis of our economy and gross inequity in the distribution of wealth exists, it is no wonder that economic status essentially dictates where and with whom community health nurses concentrate their efforts. (p. 65)

These descriptions of the disparities in health and health resources provides a social context that sets the stage for future work in *community health.* For these reasons, "increasing health and social disparities among population groups" is considered part of the socio-cultural context surrounding *community health.*

Scope and Application of the Concept

As described previously, the scope of application of the concept of *community health* provides some evidence of the use of the concept. Table 1 includes an array of

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content areas that indicate the broad nature of the concept from both a developmental perspective as well as from the perspective of health services. This breadth is noted as a conceptual problem in *The Future of Public Health (1988)*:

> While encouraging a holistic approach, this tendency to widen the boundaries of public health has the effect of forcing practitioners to make difficult choices about where to focus their energies and raises the possibility that public health could be so broadly defined so as to lose distinctive meaning (Flynn, Rider, & Ray, 1991). (p. 40)

The scope of the concept provides information about the range of the application of the concept. The breadth of the concept of *community health* is evident in the listing included in Table 1 and in the varied population groups that are addressed in its application. In community health assessments, data is collected about all aspects of its scope. If a participatory action approach is applied, the members of various communities in partnership with professionals will choose the variables that best fit their communities. A comparison of the variables tracked in commonly used community assessment instruments is included in the description of the findings of Phase II.

The literature sample and landmark works include many references to the need for the use of "public health" data to improve health, yet the process of collecting the data and the instruments used are often named "community health assessments." This was a common theme in the literature sample (Billingham, 1991; Carruth, Cormier, & Gilmore, 2002; Cowell & Cowell, 1999; Eshlemann & Davidhizar, 2000; Faruque, Lofton, Doddato, & Mangum, 2003; Gerberich, Stearns, & Dowd, 1995; Hale, 1998; Jensen & Bowman, 2002; Johnson, 2000; Kriegler & Harton, 1992; Krothe, Pappas, & Adair,

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1996; Lindell, 1997; Muir, Wilson, Rooney, O'Connor, & Murphy, 1992; Murphy, Gass-Sternas, & Knight, 1995; Plescia, Koontz, & Laurent, 2001; Ruth, Eliason, & Schultz, 1992; Shelton, Sager, & Schraeder, 2000; Stanley & Stein, 1998; Urrutia-Rojas & Aday, 1991). The World Health Organization has published a list of *Summary Measures of Population Health (2003).* In that volume, Wolfson (2002) described the uses for population based data that addressed broad determinants of health in decision making for health improvement:

> Without valid and broadly accepted measures of health, it is much more difficult to focus resources and activities in ways that have the most beneficial impact in improving health. And analogously with the economy and incomes, there are always concerns about both the average levels of health in the population and the pattern or distribution of health among individual members of the population. A fundamental question of indicator design is how to measure not only levels, but also dispersion or inequalities in health. (p. 171)

The "population health" improvement that is focused on patterns of health and inequalities shows that some of the attributes of "population health" overlap with those identified in this study with *community health.* The use of "public health" and "population health" as surrogate terms for *community* health will be described more in the following section about "Related Concepts and Surrogate Terms" The process of decision making to improve the quality of life of population groups and to solve community health problems was one of the uses of the concept that is commonly cited in both the literature sample and the landmark works.

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Surrogate Terms and Related Concepts

As described throughout this report, there are several terms that have some relationship to the concept of *community health.* Rodgers (2000) described the difference between surrogate terms and related concepts:

> Surrogate terms are means of expressing the concept other than the word or expression selected by the researcher to focus the study. . .The notion of surrogate terms is derived from the position that there may be multiple ways of expressing the same concept. . .The researcher must be careful to distinguish between surrogate terms and related concepts, which are concepts that bear some relationship to the concept of interest but do not seem to share the same set of attributes. (p. 92)

Through the analysis of the professional literature, several surrogate terms and related concepts were identified. Surrogate terms included "public health" and "population health." Related concepts included "community," "health," "primary health care," and "community development."

Several major initiatives cited in the literature sample and landmark works affected the nomenclature and use of the concept of *community health.* The term *community health* began to be used more after the Healthy Communities/Healthy Cities initiative began in Europe and Canada and came to the United States in the 1980s. For decades, the activities that addressed the health of a population and particularly, higher risk populations and/or groups with fewer resources were known as "public health." The Healthy Cities Initiative advocated for a more community based approach and this led more often to the use of *community health* to reflect this concept (Flynn, Rider, & Ray,

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1991; Poole, 1997). At the same time, the World Health Organization held a joint conference with UNICEF in 1978 in Alma Ata, Russia and adopted a "Declaration on Primary Care" as the key to attaining the goal of Health for All by 2000. At this conference, primary health care was defined with a much broader scope than that of "primary care" in the United States in that "primary health care" included several principles supporting "health and community development":

> The concept of health development, as distinct from the provision of medical care, was a product of recent thinking. Through WHO in particular, countries elaborated a number of fundamental principles for health development. One was that governments have responsibility for the health of their people, and at the same time, people should have the right as well as the duty, individually and collectively, to participate in the development of their own health. (World Health Organization, 1998, pp. 15-16)

During the 1980s, Dr. Sidney Kark applied a model of care developed on the Navajo Indian Reservations to his work in South Africa and Israel. He described the model as "community oriented primary care" and this became the model for many community based medical practices including the community health center movement in the United States (Cashman, Anderson, Weisbuch, Schwarz, & Fulmer, 1999; Shin, 2002).

The World Health Organization Declaration on Primary Care at Alma Ata was followed in 1986 with the Ottawa Charter for Health Promotion in which an agenda was developed that addressed "healthy public policy, supportive environments, community action, personal skills, and reorienting health services" (World Health Organization, 1998, p. 153). This agenda provided additional support for community participation and

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development, ecological models of health improvement and empowerment. Many of the attributes of both primary health care and health promotion were consistent with those of the concept of *community health.*

In the United States, the Institute of Medicine published its landmark work, *The Future of Public Health* (1988). In this volume, the Committee for the Study of Public Health defined "public health" broadly, "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy." (p. 1). They refined this document throughout the 1900s with additional volumes concerning "healthy communities" and wrote a follow up report in 2003 entitled, *The Future of the Public's Health in the 21st Century.* In this book, the Committee on Assuring the Health of the Public in the 21st Century defined a "healthy community" as:

> A healthy community is a place where people provide leadership in assessing their own resources and need, where public health and social infrastructure and policies support health, and where essential public health services, including quality health care, are available. In a healthy community, communication and collaboration among various sectors of the community and the contribution of ethnically, socially, and economically, diverse community members are valued. In addition, the broad array of determinants of health is considered and addressed, and individuals make informed, positive choices in the context of health-protective and supportive environments, policies, and systems. (Institute of Medicine, 2003) (p. 182)

Again, many of the attributes of *community health* derived from the literature sample and this and other landmark works are consistent with this definition. This report expanded

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the earlier definition of "public health" as promoting a "healthy community" through a "public health and social infrastructure and policies (that) support health, and where essential public health services. . ." The latter volume also addressed community participation, "where people provide leadership in assessing their own resources and need. (p. 182) This definition is consistent with the Institute of Medicine's earlier definition of public health which also referred to the work of public health as "what we . . . do collectively to assure the conditions in which people can be healthy" (p.1). These reports and initiatives indicate that public health used as a surrogate terms for the concept of *community health* in that many of the attributes of these concepts are the same.

"Public health" and *community health* have often been interchanged. Historically, public health has been used to describe governmental health activities. Spasoff (1997) described this trend:

> Although "public health" is the traditional term and still the most common in the field, the term "community health" is gaining increasing use in universities and some governments. In this chapter, "community health" will be used to refer to all population-based services, while "public health" will be used for official health services." (p. 263)

The Institute of Medicine described their rationale for defining public health more broadly:

> From the beginning, the committee believed that it was important not to limit understanding of "public health" to what health departments do. Instead, it aimed to place government activities within a broader framework that can guide a wide range of institutional participants. The intent is not to deemphasize the role of the

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public agency. On the contrary, it is to point out the indispensability of its prerogatives and functions by calling attention to the context in which they are exercised. This distinction between "public health" and "what health departments do" is reinforced by dividing the definition into three parts. By separating the *organizational* expression of public health from understanding of its *mission* and *subject matter*, the committee intends to emphasize that the goals and concerns of public health can and should be addressed not only by health departments, but also by private organizations and practitioners, other public health agencies, and the community at large. (p. 38) . . .What unites people around public health is the focus on society as a whole, the community, and the aim of optimal health status (p. 39) . . .The committee defines the *mission* of public health as: the fulfillment of society's interest in assuring the conditions in which people can be healthy. (p. 40) . . .Thus the committee defines the *substance* of public health as: organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the core of epidemiology (p. 41) (Institute of Medicine, 1988)

The Institute of Medicine's perspective on "public health" is much broader than the more traditional view that was associated with governmental entities. The characteristics of public health that are "population based" and "focused on the community" and health improvement are the same as the attributes of *community health* identified in the literature sample.

Another surrogate term used to express the concept of *community health* is "population health." This latter term became more commonly used in Canada in the

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1990s and is used more often in epidemiological contexts. Kindig and Stoddart (Kindig & Stoddart) proposed this definition of the term:

> Population health is a relatively new term that has not yet been precisely defined. Is it a concept of health or a field of study of health determinants? We propose that the definition be "the health outcomes of a group of individuals, including the distribution of such outcomes within that group," and we argue that the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two. (p. 380)

The attribute of "population health" that is the same as *community health* is that of the use of broad determinants of health and its focus on populations. There is also a stronger focus on research and epidemiology with "population health."

The nomenclature concerning the concept of *community health* has continued to evolve as the researchers and practitioners who study and implement its activities continue to refine the concept. The data indicate that there is much overlap of the use of "community health" and "public health," but some of the attributes of *community health* also overlap those of "population health." Thus these were considered surrogate terms for *community health.*

There are a variety of concepts that are related to the concept of *community health* as well. The definitions of "health" and "community" are inherent components of the concept. Throughout the community health literature, the World Health Organization definition of health as a "state that is of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1998) (p. 39) serves as either an overt or implied foundation for the attributes concerning broad

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determinants of health and empowerment (Allen, 1997; Flynn, Rider, & Ray, 1991; Galarneau, 2002; Gibbon & Cazottes, 2001; Murphy, Gass-Sternas, & Knight, 1995). Fluss (1997) described the difficulty of promoting such a broad concept:

> As health is a philosophical concept and not a fungible object in legal terms (such as food or water) or a precise scientific expression of a particular state, it cannot be so easily defined as other subject of human rights under the International Covenant on Economic, Social, and Cultural Rights. . . In a large part of the world, living standards are so low and life itself is so precarious that little more can be done to secure or to restore health other than to attempt to reduce disease or infirmity. (p. 378)

Davies (1995) also applied the WHO definition of health to community development and supported Fluss in describing the difficulties in applying this broad definition:

> We soon find ourselves dealing with matters such as levels of female education, town planning and Aboriginal self-determination, which look less and less like health issues, for all their influence on health status. The point is not just that other people do not think of them as health issues: at a deeper level, health is generally too narrow an ideal, with too few moral and political subtleties, to do justice to such large questions. (p. 226)

The World Health Organization's definition of health does not make a distinction as to how it is applied to either individuals or groups. As McMurray wrote, "There is no single variable that describes health; instead, its measurement relied on assembling a number of variables as indicators of health, each of which represents an element of the overall concept" (p. 25). The attributes of the concept of *community health* would indicate that

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each community would define the variables that answer the question of "What is health for my community?" This question leads back to the attributes of community development and empowerment. The broad focus on physical, mental and social well-being also supports the attributes of health promotion and disease prevention that are characteristic of *community health.*

The definition for "community" derived from the literature supports a perspective that the whole (community) is greater than the sum of the parts (the individuals) in that the "community" can and should make decisions for itself as a kind of "living" organism (Clarke, 1999). This view is consistent with the principles of participatory action, empowerment and community development. Reininger (1999) described the community as a "living organism" stating that "several factors influence a community's ability to build an effective community-based health promotion program." (p. 77) Descriptions of summary measures of "population health" also are based on a perspective that the "population" or "community" can be measured as a whole. Shrestha (2003) described a community level (as opposed to the individual or family level) outcome of the "empowerment phenomenon":

> The outcome of empowerment of FCHVs can be measured at the personal and community level. The outcome measure at the personal level is the self-reported change in the awareness, confidence and competence of FCHVs in the provision of contraceptive services to the community. The outcome measure at the community level is whether FCHVs have helped CMWRAs in gaining control over their fertility. (p. 324)

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The definition of a "living" community is also associated with participatory actions in which the community maintains control over its health improvement processes (Cheadle et al., 1998; Clarke, 1999; Coombs et al., 1998; Couto, 2000; Gibbon & Cazottes, 2001; Israel, Schulz, Parker, & Becker, 1998; Ledogar, Acosta, & Penchaszadeh, 1999; Ong, 2000; Shrestha, 2003)}. }.

Clarke (1999) described this view:

> We must move from defining 'community' as a physical setting in which care takes place, (towards an) understanding that a community is a "living" organism with interactive webs of ties among organisations, neighbourhoods, families, and friends. (p. 36)

The participatory action perspective is also described in related concepts. An often cited goal in the professional literature associated with "community" was its continued development defined by the members. (Baum, 1995; Brown, 1994; Clarke, 1999 ; Reininger, Dinh-Zarr, Sinicrope, & Martin, 1999; Ritchie, 2001; Rosenau, 1994). Ong (2000) discussed this definition of "community" in terms of the modern – post modern continuum:

> ...the definition of community differs as to whether it is arrived at from the 'inside out', that is being based on the interpretive meaning of community members themselves, or from the 'outside in', which represents a descriptive or normative definition by others. The differences in the definitions by members and non-members are important, particularly if a distinction is to be understood between community as a lived, social phenomenon and community as a conceptual tool. This is particularly relevant when considering the use of the term community in

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> public policy where what a community "should be" - the desirable network of supportive relationships - and what it is - an amalgam of harmonious and conflictual relationships - tend to be conflated, and community is mainly used in positive or even romantic terms. (p. 346)

Rosenau described this continuum more explicitly:

> The post-modern approach offers a comprehensive basis for a critique of modern health politics. . .In sum, it suggests that political representation via elected officials is inadequate, that political participation is manipulated, that community is a complex term and should not be taken for granted, that identity in today's world is always at risk, and that the opinion of those who speak with authority, including medical experts, need not be accepted. It questions modern tools for solving problems and urges us to use caution in attributing political, economic, or social responsibility (Rosenau, 1994) (p. 326)

Rosenau's application of a post-modern approach to "community" can be applied to the concept of *community health.* She described a need for careful use of concepts and that we not "take for granted" their complexity. The purpose of this study was to systematically analyze the attributes of the concept of *community health.* The degree of overlapping of the characteristics of "public health," "population health," and related concepts, such as "community" indicate a need to "not take for granted" the precise meanings of these concepts and their application in health improvement. For example, who chooses the variables that comprise the underlying concept becomes a critical question when determining whether the approach is participatory and encourages the attributes of empowerment and community development. These views lend support for

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the continued development of these concepts so that the impact of their meaning in research and practice can be more carefully explicated.

Thus, another concept that is related to *community health* is *community development*. The term "community development" also is used interchangeably with *community health* and serves as an attribute of community health, but the focus of community development as an attribute is on its contribution to health improvement. Community development is also used in a much broader context related to economic development, development of community infrastructure, etc. For example, Rosenau described the development of local leaders stating that "Broad community involvement is essential." (Rosenau, 1994) (p. 321) The development of local leadership could support broad community development as well as health. Harpham described urban health development as: ". . .for city government agencies it is their duty and obligation to provide health care to the most needy sectors of the urban areas (Harpham, Lusty, & Vaughan, 1988) (p. 2) The World Health Organization differentiated between the concept of "health development" and medical care: "The concept of health development, as distinct from the provision of medical care, was a product of recent thinking" (World Health Organization, 1998, p. 15)

The final related concept of *community* health identified in the professional literature, closely linked to community development, is "primary health care." There are numerous examples throughout this report of the overlapping characteristics of "empowerment" and "community development" as they relate to "primary health care that were identified in the professional literature. For example, the historical initiatives of "community oriented primary care" and the World Health Organization reports from

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Alma Ata and the Ottawa Charter support this view. It is important to consider that this view is very different than that of "primary care" applied in the health care delivery system of the United States which is based on a biomedical model and is focused on the individual. "Primary health care" in the context advocated by the World Health Organization is focused on populations and community development and is closer in meaning to the concept of *community health* than a more biomedical health care delivery service view.

The definitions and application of the surrogate terms, public and population health and primary health care and the related concepts, *health*, *community* and *community development*, include many of the same attributes of *community health* identified in the analysis of the literature sample and the landmark works. To illustrate the overlapping of the attributes of *community health* in relation to the surrogate terms and related concepts, the literature sources were reviewed to compare the actual term the author used in a literature source with the attributes identified relating to *community health* in the earlier analyses of this study. Table 2 includes a list of citations in which the authors used the terms "public health," "primary health care," "population health," "community development," and "community health" with the attributes identified for the concept of *community health.*

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Table 2. Comparison of terms used by authors in literature text with the attributes of the concept of *community health*

Terms / **Attributes**	**Population Health**	**Public Health**	**Community Development**	**Primary Health Care**	**Community Health**
Participatory Action	Clarke 1999	Green et al 2001 Israel et al 1998 Ledogar et al 1999 Leinweber et al 1994 Mooney 2000 Parry & Wright 2003 Flynn et al 1991 Gough et al 1997 Keller et al 2003	Iwami & Petchey 2002 Johnson 2000 Light 1997 Ong 2000 Rosenau 1994	Ranson 2002 Buschkens 1990	Reynolds 1992 Haglund 1997 Ritchie 2001 Stanley 1998

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Ecological approaches	Institute of Medicine 2003a	Israel et al 1998	Mishra & Waltzkin 1995 Johnson 2000 Elliot et al 1998		Kneipp 2000
Broad determi-nants of health	Institute of Medicine 2003a	Israel et al 1998	Monekosso 1993	Buschkens 1990	Improve 2002 Stanley 1998 Kneipp 2000
Health promotion and disease prevention	Badinovac 1997	Gough et al 1997 Keller et al 2003 Stewart et al 1997	Hattis & Matheny 2001 Monekosso 1993 Ong 2000 Rosenau 1994	Buschkens 1990	Reynolds 1992 Clarke 1999 Haglund 1997 Improve 2002 Ritchie 2001 Glick 1999 Williams 1998

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Community Development	Institute of Medicine 2003a Keller et al 2003	Ledogar et al 1999 Mooney 2000 Parry & Wright 2003 Billingham & Perkins 1997 Flynn et al 1991 Elliot et al 1998	Iwami & Petchey 2002 Johnson 2000 Monekosso 1993	Buschkens 1990 Ranson 2002	Clarke 1999 Improve 2002 Ritchie 2001 Rosenau 1994 Haglund 1997
Population based/Aggregate focused	Institute of Medicine 2003a Keller et al 2003	Roper 1999			Miskelly 1995

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Empowerment, **Self-care**		Ledogar et al 1999 Flynn et al 1991	Iwami & Petchey 2002 Johnson 2000 Light 1997 Monekosso 1993 Ong 2000		Clarke 1999 Ritchie 2001
Social justice		Cashman 1999 Couto 2000 Droege 1995 Flynn et al 1991 Glick 1999 Kneipp 2000 Mooney 2000 Turnock 2004	Flynn et al 1991 Glick 1999 Rafael 2000	Cashman 1999 Flynn et al 1991 Glick 1999 Rafael 2000	1999 Couto 2000 Droege 1995 Flynn et al 1991 Glick 1999 Kneipp 2000 Rafael 2000

The citations listed in Table 2 indicate that there is much overlapping of the use of the terms "public health," "population health," "primary health care," "community development" and "community health" in the professional literature sources in this study. In the literature sample and landmark works, the authors listed in Table 2 included all five of the above terms with the characteristics of "participatory action with partnerships with interdisciplinary teams," " community development," "broad determinants of health," "health promotion and disease prevention," and "promotion of healthy environments." In addition, the attributes regarding aggregate/population focus, and empowerment were overlapped with three of the five categories. Social justice was discussed in citations concerning all of the surrogate terms and related concepts except population health. This may be related to fewer numbers of citations in this evolving concept or it may reflect the more epidemiological use of the term. As this analysis included only overt examples of overlap of the conceptual categories, the actual degree of overlap may be understated. In reviewing these data, it is evident that the multiple interrelationships between these concepts indicate a need for more clarity in relation to the phenomena of community health, public health, population health, community development and primary health care.

Phase II Community Health Assessment Instruments

Analysis of data obtained from community health assessment instruments addressed the third research question for the second phase of the study: The purpose of the Phase II analysis was to analyze community health assessments in relation to the findings of Phase I and particularly to determine whether the attributes of community

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health derived from the literature in Phase I were found in the community health assessment instruments.

Assessing the health status of a local community is considered a "core function" of public health in the United States (Flynn, Rider, & Ray, 1991). The United States Centers for Disease Control and Prevention (CDC) has supported its Community Health Initiative program for the past 13 years. The purpose of the program is to support "the development of innovative systems and methods to improve the way data is used to provide information for public health decisions and policy" (U.S. Centers for Disease Control, 2005, pp. What is the Community Health Initiative section, 1). It is interesting that the program description states that "community health assessments" drive "public health decisions and policy."

The CDC Community Health Assessment Initiative uses the community health improvement model (CHIP) identified by the Institute of Medicine's Committee on Using Performance Monitoring to Improve Community Health as a foundational document (U.S. Centers for Disease Control, 2005). For this reason, this model assessment was chosen as one of the instruments to be analyzed in Phase II of this study. Other community health assessment instruments included in the analysis were the nationally recognized "MAPP- Mobilizing Action through Planning and Partnerships," (National Association of County & City Health Officers, 2001) and the "PATCH (Planned Approach to Community Health)" (U.S. Department of Health and Human Services, 1985b). Three additional instruments were included in the sample. The State of Illinois "IPlan (Illinois Project for Local Assessment of Needs)" (Illinois Department of Public Health) was selected because it was an example of a state health department

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instrument that was included in the landmark works. The Community Toolbox (Fawcett, 1998) was included because it has a social sciences orientation and was also included in the landmark works. "CHUNAS-the Community Health Needs and Utilization Assessment Survey" (Lundeen, 1992) was included because it was a nursing based survey instrument published in the professional literature designed to identify local perceptions of community strengths and needs. Each of these instruments was analyzed to determine their purposes, the disciplinary background of the organization or authors who designed the tool, and the attributes that were identified in Phase I. A description of each instrument and the analysis of the instrument in relation to the research questions is described below.

CHIP - Community Health Improvement Process

The community health improvement process supported by the IOM Committee on Using Performance Monitoring to Improve Community Health is based on a comprehensive definition of health defined in the "health field model" (Evans & Stoddart, 1990; Institute of Medicine, 1997). The performance monitoring model uses an epidemiologic approach and is intended to be used for assessing the performance of governmental public health agencies and is thus designated as public health model. This model leads to an assessment with "multidimensional perspective" that "reinforces the value of public health's traditional emphasis on a population-based approach to community health issues" (Institute of Medicine, 1997, p.2). To best identify the perspective of the community, the Committee recommended including key stakeholders that include "health care providers," "public health agencies," "community organizations explicitly concerned with health and other entities that may not see themselves as having

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any explicitly health–related roles such as schools, employers, social service and housing agencies, transportation and justice agencies, and faith communities" (Institute of Medicine, 1997, p. 20).

The community health improvement process supported in this report includes three phases: "forming a community health coalition, collecting and analyzing data for a community health profile, and identifying critical health issues" (Institute of Medicine, 1997, p. 6). As community health assessment is often described as a process in the literature sample, all three of these phases were considered in the analysis of the recommended process. Additional components of the "CHIP" model relate to continued steps in the process from analyzing the health issue, developing an inventory of health resources, developing a health improvement strategy, establishing accountability for activities, developing a set of performance indicators, implementing the improvement strategy, and monitoring the process and outcomes. For this study, only the steps in the process that supported the community health assessment (as opposed to the planning, implementation, and evaluation steps) were included in the analysis. With an epidemiologic focus, the CHIP assessment includes a wide variety of health indicators. These are used both to determine health priorities and also to serve as benchmarks for those priorities and other health status concerns. To further compare this instrument with the others in the analysis, a listing of the health status indicators was kept for each instrument. A comparison of specific health status indicators for the assessment across the various instruments is listed in Appendix F.

In relation to the attributes of *community health* identified in the literature sample, the purpose for the assessment and analysis of the health status indicators is to develop a

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health improvement strategy for a specific population group and a set of performance indicators for responsible organizations (Institute of Medicine, 1997). They called for development of a "*community health profile* (author italics) that can provide basic information about a community's demographic and socioeconomic characteristics and its health status and health risks" (p. 32). They also called for "a way to monitor performance and outcomes for communities as a whole" (p. 29). Thus this tool is designed to address "populations" and addresses "promotion and prevention of selected health status indicators."

In this model, a community coalition is recruited to lead the community health improvement process. This coalition requires an array of both professional and local expertise and should reflect the makeup of the local community including the racial and ethnic groups that comprise it. The degree of local participation, the local ownership of the process and the local and interdisciplinary make-up of the coalition determines the degree to which this process matches the attributes of *community health* identified in the literature sample. These attributes include an interdisciplinary and community based leadership group that drives a "community based," "participatory action," and/or "ecological" process. The community health improvement process is inherently a community development approach grounded in " a conceptual model of the determinants of health" (p. 36). The Institute of Medicine advocated for the accountability of the process to remain with the community. In this way, the CHIP process supports the empowerment of the community stakeholders. The process of prioritizing health issues that are best for the public good is grounded in a philosophy of social justice.

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MAPP – Mobilizing for Action through Planning and Partnerships

The *MAPP – Mobilizing for Action through Planning and Partnerships* is a public health based set of community health assessment tools that were developed as an expansion of an earlier version (APEX*PH* – Assessment Protocol for Excellence in Public Health) developed by the National Association of County & City Health Officials. The purpose for the expansion of the APEX*PH* was to "promote community responsibility for the health of the public" and "assess capacity of the entire local public health system" (National Association of County & City Health Officers, 2001, Introduction, p. 2). The APEX*PH* was designed to be used for governmental public health assessments and included both an internal assessment of the health department itself and an external assessment of the community. The *MAPP* was expanded to include more local community input and to assess public health systems in communities. This supports a view of "public health" in which local community partners are part of the public health system (National Association of County & City Health Officers, 2001).

In addition to a focus on community health status and public health capacity, the MAPP included an assessment of community perceptions, and "forces of change" in the community to provide a broader context for strategic planning (National Association of County & City Health Officers, 2001, Community Health Status Assessment, Core Indicators List). The website listed core health indicators for the assessment and these are included in the comparison of the instruments in Appendix E. An extended list of indicators that address the wide determinants of health are also listed on the website (National Association of County & City Health Officers, 2001, Community Health Status Assessment, Extended Indicators List). These health indicators address the broad

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determinants of health to promote health and prevent disease. The *MAPP* was designed to be used in coordination with the community health assessment recommended by the Institute of Medicine for the "community health improvement process."

Using a CHIP process, a community coalition would choose between the various tools to assess local health status. The inclusion of environmental indicators in the assessment provides the basis for an ecological framework. In this way the attributes of community based participatory action and ecological frameworks are supported. This use of multiple methods for the assessment enhances the ability to provide a more accurate description of the local community. Because the *MAPP* is rooted in the community health improvement process, it also supports community development and the empowerment of local communities through the coalition building process. If community based participation is supported, than the membership of the coalition must reflect the diversity of the local community. Again, if the prioritization process is conducted in the spirit of the promoting the public good, than social justice would be an underlying philosophy.

Planned Approach to Community Health (PATCH)

Another public health assessment, the *Planned Approach to Community Health (PATCH)* was developed by the U.S. Centers for Disease Control and Prevention in the mid 1980s and is listed on the CDC National Center for Chronic Disease Prevention and Health Promotion website (last reviewed August 17, 2004) as "widely recognized as an effective model for planning, conducting, and evaluating community health promotion and disease prevention programs" (U.S. Department of Health and Human Services, 1985b, A Guide for the Local Coordinator, ¶1).

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The CDC describes the *PATCH* as a "process that many communities use to plan, conduct, and evaluate health promotion and disease prevention programs" (p. CG 1-1) consistent with that attribute of *community health* derived from the literature sample. They further described the goal of *PATCH* as increasing the "capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion programs targeted toward priority health problems" (p. CG 1-1). Because the *PATCH* "was built on the same philosophy as the World Health Organization's Health for All and the Ottawa Charter for Health Promotion, which specifies that health promotion is the process of enabling people to increase control over their health and to improve their health," (p. CG 1-2) it is consistent with the attributes of *community health* from Phase I including health promotion and disease prevention, community development and empowerment.

Similar to the *MAPP* and *CHIP* processes, in the *PATCH* process, "participants are recruited from the community, partnerships are formed, and a demographic profile of the community is completed" (p. CG1-2). For this community health assessment process, the types of individuals to support the process are less defined. It is assumed that the "local coordinator" will draw participants that reflect the community into the process. The process lead by the local coordinator is not specifically defined. Thus, the local coordinator could be anyone who is concerned with a community need. Again, the degree of community participation and participatory action, the interdisciplinary expertise, and the diversity of the individuals involved is dependent upon the goals and leadership of the process. If the process is "empowering" and consistent with the World Health Organization development goals, than the process would be consistent with a

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participatory action approach in which community participants reflect the diversity of the community. The community health indicators to be assessed during the PATCH process are consistent with broader determinants of health. (See Appendix E.) Again, the degree that the philosophy of social justice is applied, would be determined after evaluating the outcomes of the priority setting process and the resulting allocation of resources.

Illinois Department of Public Health IPLAN

The Illinois Department of Public Health *IPLAN* is a "public health" model designed to support local community health assessment and planning processes. According to information listed on its website, the:

> *IPLAN* is grounded in the core functions of public health and addresses public health practice standards. The completion of *IPLAN* fulfills most of the requirements for Local Health Department certification under Illinois Administrative Code Section 600.400: Certified Local Health Department Code Public Health Practice Standards. The essential elements of IPLAN are:
>
> 1. an organizational capacity assessment;
> 2. a community health needs assessment; and
> 3. a community health plan, focusing on a minimum of three priority health problems. (Illinois Department of Public Health, What is IPlan? ¶1)

It is also "based on the *Assessment Protocol for Excellence in Public Health* (APEX-PH) instrument" and is consistent with the CHIP (community health improvement process) supporting an ecological and community development approach. It is a population based model that is designed to provide a systematic method for local jurisdictions to compare their local health data with state and national health information.

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A specified list of stakeholder/coalition participants is included in the training programs for the plan. Community participation is described as including:

> . . .but not be limited to, involvement by representatives from the following constituencies: ethnic and racial groups, the medical and hospital communities, mental health and social service organizations, the cooperative extension service, schools, law enforcement organizations, voluntary organizations, the faith community, the business community, economic development, unions, and senior citizens, as appropriate. (Illinois Department of Public Health, pp. What is IPlan?, 1).

This list allows for a leadership team with both interdisciplinary expertise and local community input. Similar to the community health improvement process, the degree of community based participatory action and diversity are dependent upon the principles and values of the local team. If the process is owned by the professionals on the coalition/leadership team, the outcomes of the assessment may be different from one in which local community representatives own the process. The local public health administrator is responsible for the IPLAN process and as recommended in the APEX*PH*, the community health assessment process begins with an internal assessment of its own organizational capacity assessment and follows with a community health needs assessment, and a community health plan. The community health assessment is largely epidemiological and includes a list of 102 health indicators that can be compared from a local community level to state and national data. The selected indicators address elements of the broad determinants of health including health resources and environmental indicators. As described on the website, "empowerment" is not a stated

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outcome of the assessment. Based on the pre-selection of health indicators for the community health assessment, this is less of a participatory action approach.

Community Toolbox

The *Community Toolbox* was "created and maintained by the Work Group on Health Promotion and Community Development at the University of Kansas in the late 1980s. The foundation for this model is in the social sciences. The mission of the Work Group is to promote "community health and development by connecting people, ideas and resources" (Fawcett, 1998, A Community Tool Box Overview and Gateway to the Tools, Background ¶1). This community health assessment model is based on an ecological framework in which the focus of the process is on the development of local partnerships that can build community capacity. They described the goal of the process as bringing about "community and systems changes" where community change affects a program, policy or practice and systems changes are "similar to community changes, but take place on a broader level" (Fawcett, 1998, Strategies for Community Change and Improvement: An Overview 3. Community and systems change) The mission and goals are consistent with the *community health* attributes of empowerment and community based, community development and applies a population based approach.

> In determining who should be involved in the process, the Work Group described: "First, it's important that the collaboration is as inclusive as possible. This means individuals from the different parts of the community for example, representatives from schools, business, and the government. It also means representatives from different levels for example, representatives from the neighborhood, the county, the state or province, and even the broader region or nation (Fawcett, 1998, Our

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Model of Practice: Building Capacity for Community and Systems Change, Who Should Be Involved?)

The process itself was also described:

> "the most important part of identifying local needs and resources is listening to the insights of group members, community members, leaders, and others while incorporating community data and history into the analysis. A document that identifies the local needs and resources of a community should ring with a richness that only a comprehensive, diverse, and large group can give" (Fawcett, 1998, Our Model of Practice: Building Capacity for Community and Systems Change, Who Should Be Involved?)

Thus a list of specific health indicators to be included in the community health assessment is defined by the local community and not predetermined as in the other assessment tools in this analysis. For example, if the community group leading the assessment effort considers access to care important, than that would be included as a health indicator. Based on the community development and health improvement goals, it would be expected that the assessment would look broadly at the determinants of the community's health and address health promotion and disease prevention. Furthermore, the degree to which this community health assessment instrument is grounded in community empowerment provides support for its philosophical base of community development and social justice.

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Community Health Needs and Utilization Survey – CHNUS

The *CHNUS – Community Health Needs and Utilization Survey* was developed by nurses for use in a local community health assessment and is based on a framework of community health classification system, the OMAHA System. (Lundeen, 1992). The OMAHA System classification used as a framework addresses "environmental, psychosocial, physiological" strengths and concerns and "health related behaviors" (Martin, 2005). The CHNUS was designed identify residents' perceptions of health and to be used in addition to other community health assessment strategies such as epidemiological studies, key informant interviews, and focus groups. The instrument has been adapted for use by several different communities since its initial development (Baisch, Friedbacher, & Lundeen, 1999). Because the CHNUS was used to assess community perceptions through a mailed survey, the broader goals for the assessment were not defined in the published account of its use. For example, it is difficult to assess the values of the community team regarding diversity and participatory action when analyzing only a component of the larger assessment. The goal of community health improvement in which health issues are identified by local residents support community and population-based, health promotion and disease prevention attributes of *community health.* The use of the OMAHA System and other assessment methods and indicators supports the attributes of population based models built using broad determinants of health. The inclusion of an environmental assessment with other health indicators also supports an ecological model for health improvement.

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Major Findings of the Phase II Analysis

In most cases, each of the community health assessment "instruments" included in the analysis actually was a set of instruments that included a variety of methods of assessment: both qualitative and quantitative. In all of the cases, the authors recommended using the tools needed to best identify the health needs of each community. Each community health assessment instrument included in the analysis was consistent with most of the attributes of *community health* identified through the literature sources. For example, all of the instruments address community development, populations/ aggregates, health promotion and disease prevention, broad determinants of health and use of ecological approaches. A comparison of the attributes derived from the literature is included in Table 3. The information in the table was developed from information derived from the text describing each instrument. Gaps in information indicate only that it was not discussed in the text used to analyze it. Furthermore, social justice was not included in the table because it was only described in the Community Toolbox.

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Table 3. Comparison of the attributes of *community health* derived from the literature sample with selected community health assessment instruments.

	CHIP	MAPP	PATCH	IPLAN	Tool-box	CHNUS
Health promotion and disease prevention and detection	X	X	X	X	X	X
Interdisciplinary, culturally competent	X	X		X	X	
Participatory action	X	X			X	
Community development	X	X	X	X	X	X
Population based/Aggregate focused	X	X	X	X	X	X
Holistic, Addresses broad determinants of health	X	X	X	X	X	X
Ecological framework	X	X	X	X	X	X
Empowerment, Self care	X	X	X		X	

The *CHIP* and the *MAPP*, both national models of community health improvement processes, included all of the attributes identified through the literature based review . Based on the information in the text describing the *PATCH* and the *IPLAN*, it was not possible to identify the evidence supporting participatory action or empowerment. The *IPLAN* is based on an older model of health improvement (the APEX*PH)* in which local health administrators were responsible for the assessment so that the process was lead by public health professionals. Both the *IPLAN* and the *CHNUS*

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were designed in the early 1990s when participatory action principles were less evident in the literature. This may only mean that although these principles were not discussed in the published accounts, they may have been actually in use by the communities that employed them. As described earlier, the degree of participatory action would vary depending on the community health improvement team and the leaders responsible for the process.

All of the instruments included indicators comprising the broad determinants of health in the assessment The inclusion of environmental health indicators supports the use of ecological models of health improvement in which health improvement is integrally connected with environmental improvement. The earlier public health models predetermined the health indicators for the assessment ensuring that the indicators could be compared at local, state, and national levels which reflect a more "modern" than "postmodern view of epidemiology. Schwab and Syme (1997) described "postmodern epidemiology" as not based on scientific control of the community health assessment process:

> The body of knowledge emerging from this process is not 'normal science,' and this is essential for a new paradigm. It makes no claim to universal truth; it is not defined by the scientist. Rather, the scientist helps reveal patterns of shifting 'local' truths, as perceived by the many kinds of people involved. (p. 2050)

In this same light, Work Group that developed the *Community Toolbox* supported a more participatory action approach. They advocated for local community ownership of the community assessment process from its onset, assessing the indicators they considered most important for their local community. How much these attributes are

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valued is determined by the health improvement team leading the process. A key question is who controls the process? Is it lead by the professionals on the team or the local community residents? The answer to these questions has an impact on the degree of capacity building and empowerment that can occur through the community health improvement process. The degree to which health priorities serve the common good and resources are distributed equitably determines the extent of the impact of a social justice philosophy.

Summary of Phase 2

The community health assessment instruments was consistent with the attributes of the concept of *community health* identified through the literature analysis. The composition of the community health assessment/planning team or coalition and the ownership of the process support the degree of participatory action and the extent of support for an interdisciplinary and diverse team that best "represents" the community. The findings of Phases I and II also indicated that the concept of *community health* is evolving. Participatory action strategies and ecological models have become more evident in the applications of community health planning techniques since the early 1990s.The community health assessment instruments designed in the early 1990s were more structured as the professionals chose the health indicators. Since that time, the community health assessment instruments and processes have become much more reflective of the need for the community to direct the processes. The *IPLAN* continues in that way so that the changes in the health indicators can be assessed over time. The *MAPP* includes much more community involvement than its earlier version, the *APEX-PH* . This requires a willingness on the part of the professionals to let the community

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members guide the assessment processes and the health indicators they deem as most important. It also means that "scientific" surveillance of data over time may not best meet the community's needs for health improvement. Schwab and Syme (1997) described these as a paradigm shift in epidemiological research: "Postmodernity acknowledges diversity and uncertainty, it accepts experience as valid and useful knowledge, and it implies a search for local understanding rather than universal truths" (p. 2050).

Phase III Interview Sample

The final phase of the study included interviews with a convenience sample of seven experts in the field of community health. As described in Chapter Three, these were mostly identified through a snowball approach. All of the individuals were from the United States although one received his public health education in Great Britain and practices infectious disease control in South America. The group included two lawyers, two nurses, two physicians and one expert with a Ph.D. in developmental studies and researches community coalition building and community engagement and has been involved in or wrote at least two of the landmark works. One of the nurses has a Ph.D. in sociology. The other nurse was working on her Ph.D. All of the rest have a Master's Degree with a specialty in public health except for one of the lawyers. All of the experts worked directly in community/public health arenas. Several had served on Institute of Medicine committees concerning community/public health and all had published extensively regarding community health issues. One of the nurses had recently served on an American Nurses Association committee that addressed public health nursing. Several had been involved in the Robert Wood Johnson National Turning Point Program which was funded to improve the public health infrastructure in the United States. All of these

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experts had many years of experience in their respective fields and several were retired or nearing retirement.

Data Collection and Analysis

The data collection was based on the study questions. During each interview, the participants were asked to define "in their own words" the meaning of *community health* and its attributes or characteristics. They were also asked to identify situations in which the concept of *community health* could be used appropriately and any related concepts. The data were analyzed in much the same way as the data from the literature sample. Each section of text was coded according to the research question and also in an inductive manner, identifying the theme of each block of text. The codes used for the literature sample were also applied to the interview data and no additional coding categories were needed. The results of the analysis of these interviews and their relationship to the final study question are described in the following section.

Major Findings from Phase III Data Collection

Analysis of the data obtained from the interviews with experts in community health addressed the fourth research question for Phase III of this study:

4. How do the attributes and context of community health as presented in the literature and in variables included in assessment instruments compare with the beliefs of key informants, including those practicing in community health and community health leaders?

In the interviews, *community health* was mostly described as a grass roots, local process in which community members are engaged in community health improvement processes through local coalitions. These processes are aimed at improving the conditions

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needed for health improvement. Community health was also described by two of the interviewees as including the provision of health care services in the community. The group lacked consensus concerning the terminology they use to describe the concept. For example, four of the experts reported that public health and *community health* were synonymous. Of these, three preferred the use of the term "public health" to *community health,* while one preferred community health to public health. Three of the experts did not use *community health* regularly in their professional practice. While one did not use *community health* at all, the other two described their work at a public health and population health level, describing *community health* as a more local concept. The varied responses of the interviewees regarding the use of these surrogate terms provided necessary background for their responses regarding the attributes of the concept of *community health.* The experts' descriptions of the attributes of *community health,* the sociocultural context surrounding its use, a more complete description of the related concepts and surrogate terms and the relationship of these responses to the findings of the earlier phases of this study will be described in more detail.

Attributes of Community Health

When asked to describe *community health* "in his/her own words," all but one of the experts described a local, grass roots process. One described these processes as being about "relationships." She said, "Community health is working with the community; more likely at a grass roots level, where you personally know people in agencies and individuals within the agencies." Another felt that these coalitions lacked the power that public health agencies would have, stating:

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> And in general, community health, with some exceptions like the Healthy Communities models. . .tends to be less powerful, tries to band together to get power, rather than the powerful joining the others to get better health. So you don't see a lot of CEOs in corporations and owners of large businesses and editors of newspapers in most community health coalitions. You see persons representing social service agencies, public health workers, persons who have raised their family and they're now out in the community and being active as volunteers.

This interviewee also discussed the statutory requirements for accountability for health improvement inherent in governmental public health systems that is not required for coalition initiatives. In his analogy of the use of a carrot and stick approach, he described the coalitions as having the "carrots," while the governmental entities had potential for using a "stick" if needed for health improvement.

Those who viewed *community health* as synonymous with public health defined the concept in terms used in the Institute of Medicine reports which were summarized by one participant as: "It represents the conditions under which health and well-being and the associated behaviors can occur." He further described this process as: "community systems change." Another supported this view, stating:

> Where people work together to achieve conditions in which people can be healthy and depending upon the problem that they have, the strength, the interest, the availability, or another component of the system will take the lead, but they'll all agree to work together; where in this case community means coherence.

Creating or assuring conditions for health improvement has been a common theme since the Institute of Medicine defined public health in this way in its recommendations for

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improvements in the public health system in the United States (Institute of Medicine, 1988, 2003). This definition was echoed by five of the participants who reported they had worked directly in public health systems in the United States during their careers.

Community health was viewed by all of the interviewees except one of the nurses as focused on populations. There were different opinions regarding what populations and how they were engaged in health improvement processes. For example, those who viewed *community health* from a population health perspective viewed the concept more broadly. This definition included the broader determinants of health including community development issues such as housing and education. The nurse with the differing opinion felt that public health was an even broader term and said:

> People who use that (term) – community health - do not have a population perspective. . . What they often mean is a kind of abstract subgroup you know, like teens or single mothers and they want to do some program for such groups.

Her view was similar to that of another respondent who defined population health in much more explicit terms as, "the definition and measurement of health outcomes and the roles of determinants." He further differentiated population health as being focused on "quality and quantity in health outcomes and addressing disparities." This is a view of the concept that is defined by professionals, rather than one identified by local community members within local coalitions. This expert acknowledged this issue and said, "Whether a local participatory process is more important than a focus on outcomes is a legitimate debate."

Six of the interviewees included a broad view of health as an attribute of community health. Most described these as components of the health field model (Evans

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& Stoddart, 1990) in which health is defined by "broad determinants." One stated that "public health" should have been included in the health field model in addition to the category of "health care". Although it is considered one of the determinants of health, two of the interviewees specifically linked community health with the environment. In addition, one described the inclusion of an ecological model in community health. He linked an ecological approach with "community systems change":

> Once you've accepted an ecological approach, and before that we're talking about multiple unrelated factors affecting multiple unrelated outcomes, then the logic that a dose of one thing is going to move enough behavior of enough people to move population level outcomes, particularly when a commodity called services is in scarce supply, makes it improbable that it will happen.

That is, working on one health issue at a time will not provide enough scope to change health outcomes in population groups. All but one of these experts advocated for addressing multiple "determinants" of health to promote changes in health systems.

One of the nurses strongly advocated for this multiple level approach and stated that she had realized much earlier in her career that for larger scale health improvement to occur, the emphasis needed to be on changes in health policy. She was concerned that this was not what was being taught in schools of nursing, where she felt the focus was on individual health care within the community, such as visiting nursing and home care. She said,

> It is just health care in the community, which is fine, but that's not public health. Mostly, almost universally, schools of nursing teach community health in that sense of health care in the community and do not teach or even understand. . .

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> what is meant by policy. . . You can't do what you need to do without policy support and policy always means the allocation of resources.

One of the physicians also described one of the major purposes of population health research as informing policy development.

The link to vulnerable populations and the provision of a safety net for health care services was another attribute derived from the interviews. Again, there was not consensus about this issue. One of the interviewees linked community health to minority populations and the "poor," while another linked community health to "health care in the community." A third stated that *community health* was "a marriage of public health and public services." He explained this further:

> Community health is protected by making sure that individuals within the community don't just have their populational concerns addressed, but they have their individualized health concerns addressed.

The other four were consistent in their message that the purpose of community/public health was not direct service, it was assuring conditions to promote health. One described this position as:

> Health care is not to be confused with community health. That access to services, particularly clinical preventive health services, community health services are good things. They should be maximized, but they're not to be confused with either widespread behavior change or improvement of population level outcomes.

In this text, although he indicated that health care is not *community health,* he alluded to "clinical preventive services, community health services" as similar services. This description is confusing in that clinical preventive services constitute much of the

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primary care delivery system in the United States. He further described these as different from population level outcomes These experts described the goal as improving population level outcomes. They differed in their use of the terms "community" or "public" or "population health" to describe this goal.

Several of the interviewees discussed health promotion as an attribute in terms of changing health systems. As one interviewee reported, "you get health promotion and you change the conditions." The expert who made the previous statement described this further as "expanding the options available for individuals and population groups to make lifestyle changes." In an article she wrote and referenced in the interview, she stated:

> Implicit in this view of organizational decision-making and individual choice-making as they affect health-relevant patterns is the notion of a pyramid of decisions. The decisions taken at the "higher," more powerful organizational levels, set the range of options available at lower levels. This may be seen in the ways in which both federal government or multinational and large scale corporation policies concerning food, energy, transportation, or antipollution enforcement ultimately affect not only the policy choices of public and private bodies at state and local levels, but also the individual in his and her daily choices about diet, residence, exercise, and pace of life.

The two experts who supported *community health* from more of a direct care perspective, also included health promotion as a focus of community health improvement through either one to one or group education efforts.

Health promotion was the only attribute that crossed all of the interviews and even that attribute was supported in differing ways. All of the interviewees supported a

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definition of *community health* that included use of broad determinants in health. Yet there was some confusion over whether direct care in the community should be considered an attribute of *community health* and if so, to what extent. In summary, there was little consensus across the interviewees on any of the attributes derived from the interviews. Most of the interviewees supported a population based view of *community health* at a grass roots level, but several did not use *community health* in their lexicons. The overlapping attributes of "population health" and "public health" and "community health" identified by these "public health" experts indicated a need to further clarify these concepts.

Sociocultural Context Surrounding the Use of CommunityHealth

The context surrounding the concept of *community health* derived from the interview data concerned historical trends, the impact of population shifts on *community health,* philosophical beliefs about health and health care and the uses of the concept. One of the nurses began her interview with a discussion of the changing population trends in the United States. She linked this with the changes in health care delivery and described a need to address the growing aging population members of which have chronic diseases needing community level interventions:

> ...Look at community level interventions around chronic disease, because that is going to be bigger and bigger. . . And so for example, what about some extension of health care delivery into the community that looks at a community level intervention . . .kind of group level intervention around basic diabetes care or something.

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She placed this in the context of the changes in health care over the past thirty years in which public health systems were reduced due to limited budgets and became more focused on population level services. This led in part to fewer direct services and a much smaller safety net within communities for health care resources for the poor and/or at risk populations:

> I see on the horizon that we could and should really address creating systems that integrate public health or community health and services of the elderly. Because I think those have been, they've been really separate kind of thought processes at least for the past ten or twenty years. . . I think probably years ago they were more integrated, but I think the last, certainly the last ten, probably the last twenty, we've really gone our separate ways and you know, services are provided for the elderly through you know physician offices, nursing homes, and home health has gone its own way in a lot of ways and partly its our doing.

This context indicates that if community health assessments are based on both on epidemiological data and the felt needs of the constituents, major shifts in services due to the aging population will be necessary. The reduction in direct community services that were linked to public funding that already has occurred will continue to make it more difficult to fund these services for low income and other vulnerable populations.

This interviewee acknowledged the impact of changing reimbursement patterns on health care delivery systems. These changes support the view of the interviewees that policy level changes are needed to make "community systems change." For example, the option for third party reimbursement (including public Medicaid and Medicare) of direct

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care in the community for many health concerns led to a wider private home care system replacing some of the traditional public health nursing roles in direct care.

Another significant historical event was the terrorist attack on the World Trade Center in New York City and the subsequent anthrax threats in various areas in the country. Two of the interviewees described the impact of these events on the public health system as "militaristic." They felt that this had a negative impact on the public health system in that funding for "preparedness" led to a different set of priorities for local public health systems. One said:

> I mean the priorities and the authority come from the trigger that is pulled by the military anti-terror imperative and if you read the stuff and talk to people this kind of planning and exercise at the same time that their (local health departments) ordinary budgets are being cut by the state and by the feds for this one purpose, you will see the priorities twisting and they will say they just don't have the staff to do what is common, everyday population risks, whereas the terrorism risks are so small so everything is twisted on balance.

The other interviewee also described the use of the funding by local coalitions in a way that did not support the building of public health infrastructure. Regarding his state's public health system, he said, "There is no organization around the county or geopolitical area and therefore accountability is a terribly, terribly difficult thing." The outcome of this "preparedness" was "political heads outsourcing skills to the private market. Lack of information, communication coordination, no leadership." These views support the need for more resources for the basic services offered through local governmental health entities rather than local coalitions.

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From a philosophical, rather than historical perspective, the interviewees discussed the right of individuals to health care in relation to *community health.* One of the interviewees described the right to health care services for all:

> Health care delivery is about, at its core, is about using the most basic ethics or human rights message, everyone, no matter how they're placed in society, should have some basic access to heath care services. It's essentially a violation of human rights. . .

He further described the difficulty with achieving this goal:

> So without a doubt in the United States we have major problems with it, and have to recognize real serious issues. . . This remains a flaw in the health care system of the United States.

The World Health Organization goals for Health for All for 2000 and the United Nation's Millennium Development Goals were linked to this issue by another interviewee. His current work relates to improvements of water quality in South America. He compared the goals of Health for All and the Millennium Development Goals to health improvement:

> . . . If you look back at what people were talking about in "Health for All," those kinds of concepts, they were founded to some extent on health for everyone as a human right, but it certainly is hard to argue with conceptually, but they may have been diluted over time; it could be a function of two things, either people being realistic or cynical and suggesting its much broader than ever imagined or people were just saying that a conceptual framework doesn't get the job done and what we needed to focus on was getting rid of disease. . . If you look at the Millennium

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> Development goals, that on the other hand is a huge priority. . . In the MDG's, you're not just looking at targets around water and sanitation, you're looking at targets associated with poverty reduction and reduction of infant mortality. . .it doesn't say anything about health, it says access to safe drinking water and access to sanitation, you have to make the connection, but the connections are easy for everybody to make. . .

This interviewee was very pragmatic in his approach to his work in "public health." (This interview was one who did not use *community health.)* He linked his work to broader determinants of health through water quality improvement and reported that he saw close links between the Millenium Development Goals and his work. He thought the philosophy of "health for all" was too broad to be practical. In both of these examples, the interviewees described individuals having a right to health care services, but described the realities of implementing these broad goals.

In summary, the sociocultural context described by the interviewees included historical trends related to reduced funding for basic community and public health services resulting in fewer direct services available through local public health systems. One interviewee described the changes in the demography of the population that will result from a growing aging population. If health priorities are determined by local community health needs and strengths, than the services currently available may need to be adapted.

The interviewees also described the changes in the public health systems in the United States due to the bioterrorism responses. These were viewed as drawing scarce

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resources again from local public health systems to prepare for priorities that have much less probability of occurring than other public health threats.

Finally, the context of community health internationally since the 1970s has focused more attention on basic human rights through the WHO goals for Health for All and the more recent United Nation's Millennium Development Goals. The interviewees discussed the difficulties of meeting the goals of these organizations with the current distribution of resources.

Related Concepts and Surrogate Terms

All but one of the interviewees used "public health" and "population health" as surrogate terms for *community health.* Four of the experts used public health and community health synonymously. Of the four who viewed "public health" similarly with "*community health*," three preferred the use of the term "public health" to community health and one, the researcher engaged in studying community health processes, preferred use of "community health" to "public health." Two of the other interviewees preferred use of the term "population health." One of these used "public health" and "population health" synonymously, while the other noted conceptual differences between the two. Three of the experts did not use the phrase "community health" regularly in their professional practice. One said, "Community health is not a term we use in my circles." The other two focused more on the connections between public health and population health, describing *community health* as a grass roots, coalition building concept in which local community members drive the process. One of the physicians linked the three terms, stating, "Community health, public health, and population health are all synonyms

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for the health of the public." The interviews indicated that there is no consistent use of the terms "public health," "population health," or "community health."

In describing the connections between *community health* and public health (and as described in the attributes), all of the experts described public health as addressing populations; four specifically described the mission of public health as directed toward the "conditions under which health and well-being and the associated behaviors can occur." In referring to the differences, one said:

> I don't personally get hung up in differences between community health and public health. Clearly for me, in public health we're working on a level with the population. And in community health work, we are working within a relationship with the community.

Four of the interviewees used the "Essential Public Health Services" identified by the Public Health Functions Steering Committee of the U.S. Public Health Service as essential to "public health" and not necessarily to community health. One particularly described the accountability for public health services that he felt was not as crucial in *community health*. He said it was difficult to address the accountability issues in *community health* since "communities" develop at a local level based on the needs of the community group. He said:

> So with the kind of antiestablishment, anti-intellectualism as the unifying theme, so the who is different, the where is different because of the lack of attention to boundaries, and therefore the outputs or the accountability is different. Because it is very hard to get your arms around the numerator, the denominator, to demonstrate accomplishment.

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He referred back to the "Essential Public Health Services" as he further described the governmental public health strategies available to protect the citizenry. One of the nurses described this regulatory function as different from *community health* strategies as well.

The interviewees also described "population health" as a surrogate term. One of the nurses made a distinction between *population health* and *public health* and *community health*:

> I think of population level health or public health practice as really service to a broader, larger, aggregate that isn't necessarily going to get down to the community level, or be able to recognize differences, the smaller neighborhoods, community level. But its critical because nobody else does that. No, very few entities besides public health practitioners really do aggregate data, for example, and look at a population level in a monitored trend that changes in the population level over time. It's nobody else's job to do that.

One of the physicians defined population health very specifically in epidemiological terms as the definition and measurement of health outcomes and the roles that health determinants play in shaping the outcomes.

One of the interviewees, who viewed community health as including "health care" services, described the link between access to care, public health and *community health.* He said:

> Community health is protected by making sure that individuals within that community don't just have their populational concerns addressed, but they have

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their individualized concerns addressed. It's that health care that ensures that the community itself can be protected.

He further stated that, "'public health' has largely tried to move off of that, any access to health care services."

The two concepts related to *community health* derived from the interviews were "community" and "coherence." Community was defined by one of the interviewees as people in a place that share an experience. He further explained it as:

. . .the triple definition of community is those who share a common place, experience, or interest. And, you know, if I'm a part of a group that's traditionally experienced discrimination and all the stressors associated with that, I'm really in a community of interest and experience . . . And some people, their interest is about a concern, and that may be the community of interest . . . You know, I care about child immunization no matter where the heck it is and so on and that transcends place.

This is the same view presented by the nurse who did not think that *community health* was considered a "population level" concept. Her view of "community" was one of subpopulations related to a specific projects, "What they often mean is a kind of abstract subgroup you know, like teens or single mothers and they want to do some program for such groups" Yet she later reported that *community health* concerns populations.

The other related concept that was derived from the interviews was that of coherence. One interviewee described stated that "public health can only work if there is an efficient, coherent, interactive public health system." He said, "community in this case

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means coherence." These terms together describe an entity that can be formed for many reasons, but holds together as a dynamic group that addresses community health issues.

Summary of Phase III

This phase of the research was conducted to address the final research question:

4. How do the attributes and context of community health as presented in the literature and in variables included in assessment instruments compare with the beliefs of key informants, including those practicing in community health and community health leaders?

In this section, the data derived from the interviews will be compared with the attributes, sociocultural context, and related concepts derived from data collected in Phases I and II.

In reviewing the data from the interviews, it is important to consider that the interviewees were experts in the field of public health. They were all grounded in the classic "public health" literature and often mentioned documents from the Institute of Medicine, the World Health Organization or the US Public Health Service in their interviews. Three of the seven reported they had worked in governmental public health systems. The area of specialty of one of the lawyers was public health law and this individual consulted with local and state health departments regarding these issues. Another interviewee was currently researching population health issues at the time of the interview. These backgrounds enabled them to provide rich information about community health issues, but also meant that they were largely grounded in "classic" public health perspectives. During the interviews much of the time was spent differentiating between the surrogate terms "public health" and "population health" with regard to the concept of *community health.*

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The most common attributes of *community health* derived from the interviews was that it was viewed as participatory and local and focused on population/community level services and outcomes. This was consistent with the findings in the other phases of the study. This was mostly described in two ways. First, five of seven of the interviewees described *community health* as developed through local coalitions who engaged in health improvement activities to address local community health issues. The second attribute was described in terms of being population based. All but two of the interviewees described *community health* as addressing populations rather than individuals. The two other interviewees described *community health* as direct care of individuals or "subgroups" in the community. Although supporting a local view of *community health*, one interviewee felt that community coalitions could be less accountable because they did not have the statutory support for health improvement. The accountability of more loosely aligned coalitions was self directed, rather than due to more external reasons. Furthermore, he felt that because they were based on issues of interest and not geopolitical jurisdictions, they had "no denominator" with which to compare data. This view was similar to that demonstrated in the IPLAN in which a predetermined and consistent set of health indicators could be used to compare local, state and national data over time. All but two of the interviewees supported this more epidemiological approach to health planning and supported a process led more by the professionals than the community members. On the modern-postmodern continuum described previously, this would be a more "modern" view of participation.

The link with the attribute of health promotion and disease prevention evident in both the literature sources and the community health assessment instruments was also

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described by the interviewees. One stated directly that health promotion and disease prevention was an attribute of community health. Others described it more indirectly in their support of the definition of community health as the "conditions" that promote health.

One interviewee described community health as the processes that support health improvement, community development and empowerment. This was the researcher whose research focused on the processes of community engagement and coalition building. His perspective differed from that of the others whose perspective was more epidemiological. In other words, the majority of the interviews focused on the epidemiological view and its role in health policy as attributes of *community health*

Several of the experts discussed the reductions in funding for community health that have had an impact on service provision. Two specifically described the policy changes and funding shifts after the bioterrorism attacks in 2003. Interestingly, they both described these policies as militaristic, directing funds for "preparedness" programs rather than more needed, "basic public health services." Both of these individuals had much experience working in governmental public health. Although the sample of literature was from 1990 to 2003, the descriptions of reduced funding for *community health* services were evident throughout the sample and before the attacks. The responses of these interviewees reflected a change in policy that further affected public health systems on top of a trend of reductions in funding. These "militaristic" policies provided a more recent context surrounding the concept of *community health.*

Two of the interviewees described *community health* in terms of health care services. Access to care was a common content area of *community health* that was

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included in the literature sample and in the community health assessment instruments. This was considered a component of the attribute of community development. Two interviewees also specifically described community health in terms of the safety net for health services for poor and/or vulnerable populations.

The focus of most of the interviews related to the use of the terminology for the concept of *community health.* All but one of the interviewees preferred the use of the term "public health" or "population health" over "community health". The interviewee attended a public health school in Great Britain only used the term "public health." The interviewee researching community engagement preferred *community health.* The most notable evidence of this is in the interviewee's descriptions that "public health" and "*community health*" are synonymous. Most felt that the two concepts only differed in the regulatory role of "public health." If "public health" is defined broadly, than *community health* would be considered part of it. Several of the interviewees also defined population health as a synonym for *community health.* The researcher of population health issues defined this concept in more epidemiologic terms stating that "in population health there is significant attention paid to multiple determinants of health and the patterns between them." Although many of the articles in the sample described a population focus, the term "population health" was used more often in the latter years of the sample. This provided evidence of the evolving nature of these concepts.

Based on the attributes described in the interviews, the community health assessment instruments and the interviews, population health is a broader term in that it encompasses all of the "determinants of health." Public health is one of the multiple determinants of health in that it is defined by the conditions that are needed to keep the

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public healthy including the "ten essential services." When public health is defined broadly, c*ommunity health* may be the same, but the concepts differ mostly in their accountability. Public health is required to be accountable to their broad constituency, while the coalitions that address *community health* may be accountable to their members. Official governmental public health entities also have regulatory and police intervention strategies not available to *community health coalitions.* Thus, c*ommunity health* is considered a component of the larger field of population health in that smaller community groups or coalitions define themselves in terms of the broader determinants of health and philosophical beliefs in participatory action, community development, empowerment, and social justice. The following figure includes a summary of the relationships among these three concepts.

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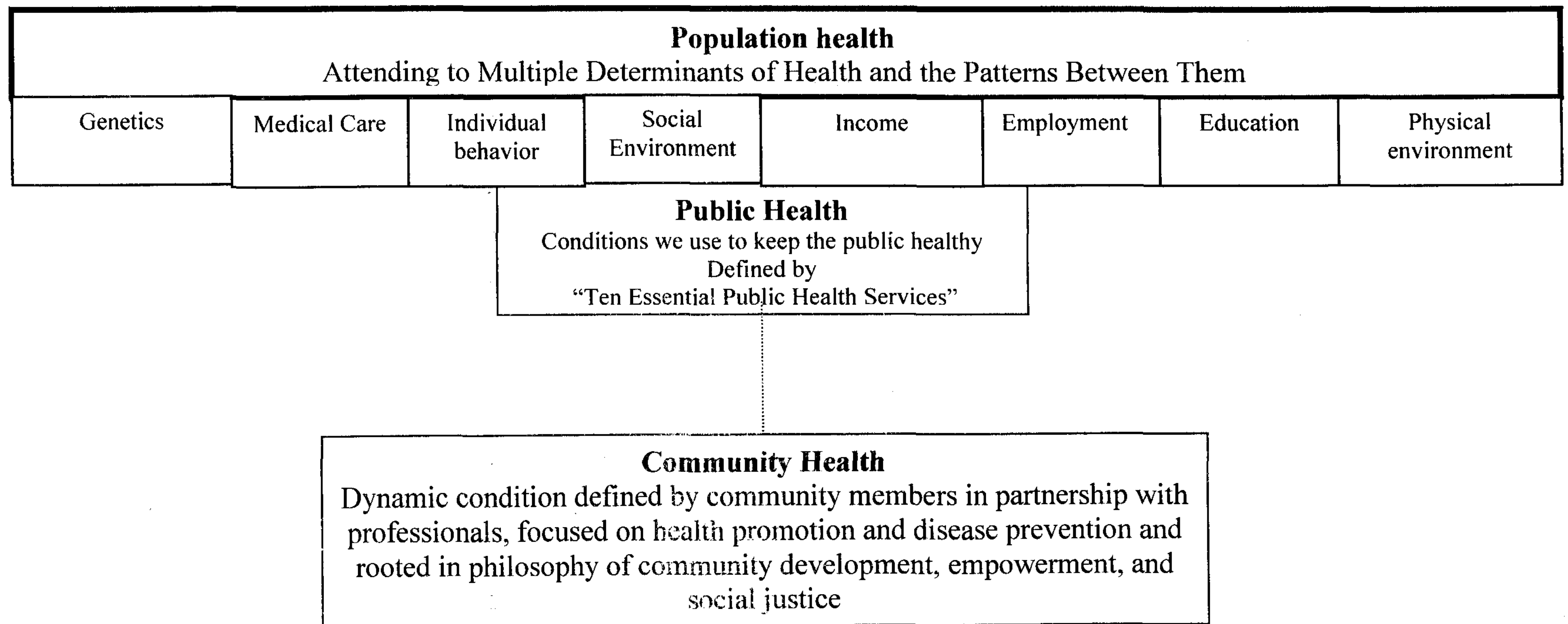
Figure 2. Relationships between the definitions of "population health," "public health," and community health.



Limitations of the Study

This study was designed to be a systematic analysis of the concept of *community health* that included a comparison of a random sample of sources of literature with instruments designed to assess community health and interviews of community health experts through a rigorous, triangulated approach. Nonetheless, there are limitations that must be acknowledged.

The sample of literature was drawn from a vast population of articles and other sources concerning *community health.* Although the sample was randomly selected, there may have been important documents that were missed because of the population volume. This may also have been true of the landmark documents. Four experts recommended classic works in *community health,* but other experts may have chosen a different list of sources. Furthermore the sample was limited to a thirteen year period, and it was clear that even in this time period that the use of the concepts were evolving. In the future, the sample selection would include population health, a term that was used much less often in the literature when the study was designed.

The community health assessment instruments and interviewees selected for phases II and III were convenience samples. The community health assessment instruments were mostly those that were recommended by major public health professional groups in the United States and most are widely used. Yet this list did not reflect a rigorous analysis of the community health assessment instruments available for use. A more rigorous sampling scheme would have identified a broader group of instruments. This is an area for continued exploration of this concept. The interviewees were mostly considered experts in "public health," although they came from varied

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disciplines. Future studies could include a larger group of experts from either the same group or other related disciplines. The interviewees were also all professionals. As *community health* has been defined as a "local" entity, it would be important in future research to examine the beliefs of lay individuals regarding this concept.

Finally, the study is limited by the volume of text in the study itself. The systematic method applied to this research provided a means of addressing biases in the sampling of the information presented Yet, the researcher categorized the text, the information in the instruments and in the interviews inductively and according to the study questions. There may have been ideas that were not included as the material was synthesized into larger categories. This limitation was addressed in part by including the coding categories in Appendix D and will be further addressed by disseminating the findings in a publication for continued discussion of the evolution of the concept.

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Conclusions Regarding the Sociocultural Context Surrounding the Use of the Concept of *Community Health*

The purpose of this research was to identify the current status of the concept of *community health* and the sociocultural context surrounding its use. Rodgers' Evolutionary Model of Concept Analysis was chosen for the design because in this method, the dynamic nature of concepts is acknowledged. Rather than viewing concepts as the static "building blocks of science," concepts are viewed as evolving within their sociocultural context as the concept is adapted to the situations in which it is used. In the case of the concept of *community health,* its multidisciplinary use increased the complexity and the "fuzziness" of its meaning (Rodgers, 1993) There was evidence in the analysis of the professional literature and the interviews that individuals in various disciplines used the term "community health," but did not define the concept in the same way. There also was no clear pattern among the disciplines concerning the use of the concept. In a search of the references in the sample of analyzed literature for the use of the terms community health and public health by the different disciplines in the study, authors from nursing and sociology used community health more often, while authors from the field of medicine and public health used public health more often. Furthermore, there were 181 citations in the sample literature in which the author used both terms in the literature source. The lack of clarity was also evident in the descriptions of the attributes of *community health.* For example, in many of the articles in the literature and in the interviews, while the physicians and "public health" specialists promoted more of the biomedical, epidemiologic strategies for health improvement, there were clearly those who supported the more postmodern end of the continuum with participatory actions

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health experts. The discussion of the results, conclusions and implications of these analyses are presented in this chapter.

Conclusion and Discussion Consistent with Rodger's (2000) Framework

Conclusions Regarding Attributes

The first phase of this study included an analysis of the literature elicited from the databases of Sociological Abstracts, CINAHL, Medline (Ovid version), and Academic Search Elite to best identify sources of literature from the disciplines of sociology, nursing, medicine, and public health. In addition, a list of classic/landmark works was elicited from recommendations of experts in *community health.* These included a list of books, articles, and websites that were considered important sources of information concerning the concept of *community health.* The professional literature articles were analyzed in a heuristic process to determine its attributes, the sociocultural context surrounding its use, and surrogate terms and related concepts. The results of Phase I included a definition of the concept of *community health* that was derived from the current professional literature: *Community health* is a dynamic condition defined by its members through participatory action in partnership with professionals of disciplines identified by the community members and is based on philosophical beliefs of community development and empowerment. Its focus is on health promotion and disease prevention for the entire population within it using an ecological model of health improvement and including broad determinants of health. The evolution of *community health* is individually defined for each community through locally developed community health assessment processes. Based on the needs of each community, community health is applied differently. The sociocultural context in which community health occurs is

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rooted in the value of social justice, yet community health takes place in a global economy in which there are wide disparities in wealth and in which governments have fewer resources for community development and health improvement. The terms "public health" and "population health" were found in the analysis to be surrogate terms for "community health." In addition, *community*, *health*, *primary health care*, and *community development* were concepts that were related to *community health.*

The results derived from the analysis of the data in Phase I was then compared with the variables and processes included in national and state community health assessment instruments. Finally, the data obtained in these two phases of the study were compared with perceptions of the concept of *community health* as reported in interviews with experts in community health in the United States.

Five attributes were found to be consistent in the analysis of the literature sources, the community health assessment instruments, and the interviews. These included:

- Population based.
- Broad determinants of health
- Health promotion and disease prevention
- Community development
- Ecological approaches/healthy environments

This means that the condition of *community health* is based on a definition of health that includes "broad determinants." That is, housing, education, poverty, the environment and other determinants including more traditional health conditions and behaviors all affect the health of the community. The scope of the services and programs described in the literature sources and the wide array of the health indicators included as variables in the

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community health assessment instruments provided evidence for inclusion of broad determinants of health in the definition of *community health.* The discussion of the interconnectedness of these "determinants" with their physical and sociocultural environments supported the inclusion of ecological models of health .With this view, health is improved as a part of the larger community development in interconnecting or "ecological" ways in concert with the surrounding environment. The focus of this development is on the population as a whole. This holistic view supports the perspective that the community is a "living organism" and is greater than the sum of the individuals that comprise it.

In the analysis of the literature, the work of *community health* was found to be focused on health promotion and disease prevention rather than biomedical models of intervention. This was supported by the wide array of health promotion and disease prevention services described in the literature and the accounts related to the need to refocus health services on models of prevention. One of the landmark works that was often cited in the random sample of literature described the ineffectiveness of tertiary care models on overall health improvement. (McGinnis & Foege, 1993). McGinnis (2001) wrote more recently about the need for a longer range vision for health policy. He reported on the lack of impact the wealth of empirical data has had on health policy and the need to shift resources to health promotion and prevention activities:

> As long as accounting procedures and time horizons are focused predominantly on the immediate, institutional decisions and policy changes important for prevention will take a secondary position. Wider application of a calculus that advances insights into the magnitude of health gains from preventive

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interventions, their cost effectiveness, and their comparative costs and returns relative to other health-related investments should enhance support and yield better-informed policy decisions. (p. 394)

There were three additional attributes derived from the professional literature including: participatory action, diverse and interdisciplinary, and empowerment that were not included in both the community health assessment instruments and the interviews. The participatory action attribute was described by the interviewees, but was included as a variable in only one of the community health assessment instruments. The interviewees focused on the "grass roots" aspect of this attribute describing *community health* as more "local." That is, local community members are responsible for and lead community health improvement processes rather than professionals. Several of the interviewees differentiated this attribute of *community health* from "public health" describing *community health* with more of the principles of community based, participatory action where the community members control the processes of decision-making. In contrast, decision-making in "public health" was primarily based on epidemiological frameworks where decisions are made by the professionals involved in the process. Four of the six community health assessment instruments were developed by committees or groups with "public health" backgrounds who planned that the instruments would be used more by governmental public health agencies. Several of the interviewees were working with governmental public health agencies as well. It was evident that there was a tension between the need for "scientific" data driven decision-making and more community driven, participatory decision making. Although the interviewees expressed a belief that community members should be "involved," the more "public health" view was that

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control for community health improvement processes would be best served if supported by "evidence" of health risks provided by data. One interviewee described decision-making in *community health* as having "no denominator" for comparisons of data as there is in a more epidemiological approach. On the other hand there was a growing body of data in the literature sample, that supported more "postmodern" views in which local member control decision making in regard to health in their own communities (Rafael, 2000; Rosenau, 1994; Schwab & Syme, 1997). Light (1997) described the movement toward more postmodern approaches as:

> These developments imply a paradigm shift comparable to the Reformation. . .one in which the powers and the purse are aligned to promote health by people owning the problems and running programs to address them on a decentralized, local basis (p. 140)

In this view, the community members identify and prioritize the issues, develop the programs to address them, and control not only the processes for achievement, but the funding as well.

In the same philosophy as participatory action, the empowerment attribute was described only in the professional literature and was not described by the interviewees or in the community health assessment instruments, except for the *Community Toolbox*, in which the aim was to "build capacity for community and systems change" (Fawcett, 1998, p. 1). When the interviewees were asked to describe *community health* "in their own words, " empowerment was not described. It may be that if philosophical approaches to community health were explored in more depth, these attributes would have been supported. Yet this finding was consistent with the principles of participatory

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action. Philosophically, "empowerment" includes developing competence and confidence (Shrestha, 2003) in the skills needed for people to "gain greater control over their lives and health" (Kemp, 2003, p. 145). It also means that community members develop the skills needed to lead their own health development, while professionals play a different role as collaborator or facilitator, but not leader. The focus of most of the community health assessment instruments and the interviewees was on the identification of health risks, not the processes involved in identifying these risks. The *Community Toolbox* was designed to address these processes by expanding the capacity of community members to act on their own community health.

If community members own the process, they also choose the team needed to improve their health. Another attribute of *community health* derived from the professional literature was described as interdisciplinary and diverse. To fulfill this attribute, community members would choose the membership of the team that would best address the health issues for the community. Each community would choose a team that reflects their diversity and includes the expertise needed to address the community needs and building on community strengths. If the issue is political, the team may include a lobbyist or a lawyer. If the issue is broad health education, the team may include someone with a community health education background or a media specialist. The key element is that the community members determine the members who comprise the health improvement team.

The degree of support for each attribute varied depending on its use. For example, some community health assessment strategies described in the instruments were more participatory that others. The purpose of the *Community Toolbox* was to build

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capacity within community infrastructures (Fawcett, 1998) such as the process of building community leadership. Thus local empowerment and participatory action are key aims of this community health assessment tool. The purpose of the other community health assessment tools was to identify community health priorities based on the health indicators listed in the instruments. The attributes of participatory action and empowerment are less evident in these instruments, yet community development for populations was inherent in the health improvement processes supported by these assessment tools. This was consistent with Kersbergen's finding in her analysis of the concept of *managed care* in which she reported that "the "value of each attribute varied depending on the context and the pragmatic utility" (Kersbergen, 1996, p. 178). That is, the community health assessment tools that were focused on identifying local health risks supported the epidemiologic, population based approaches over local, participatory approaches. This was also evident among the interviewees. Although some felt that *community health* was "local" and community members should be involved in the community health improvement processes, there was strong support among the interviewees for more population based, epidemiological decision-making. On a continuum of "modern-postmodern" approaches, the tension regarding the ownership of the process was evident in the more "modern" views of the professionals who felt that community members should be "involved" but not lead the process. Community members could not be held accountable statutorily for the outcome, as a governmental entity could be. In the more "post-modern" participatory paradigm, the community groups would hold themselves accountable for the community health improvement outcomes.

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Conclusions Regarding the Sociocultural Context Surrounding the Use of the Concept of *Community Health*

The purpose of this research was to identify the current status of the concept of *community health* and the sociocultural context surrounding its use. Rodgers' Evolutionary Model of Concept Analysis was chosen for the design because in this method, the dynamic nature of concepts is acknowledged. Rather than viewing concepts as the static "building blocks of science," concepts are viewed as evolving within their sociocultural context as the concept is adapted to the situations in which it is used. In the case of the concept of *community health,* its multidisciplinary use increased the complexity and the "fuzziness" of its meaning (Rodgers, 1993) There was evidence in the analysis of the professional literature and the interviews that individuals in various disciplines used the term "community health," but did not possess identical concepts. There also was no clear pattern among the disciplines concerning the use of the concept. In a search of the references in the sample of analyzed literature for the use of the terms community health and public health by the different disciplines in the study, authors from nursing and sociology used community health more often, while authors from the field of medicine and public health used public health more often. Furthermore, there were 181 citations in the sample literature in which the author used both terms in the literature source. The lack of clarity was also evident in the descriptions of the attributes of *community health.* For example, in many of the articles in the literature and in the interviews, while the physicians and "public health" specialists promoted more of the biomedical, epidemiologic strategies for health improvement, there were clearly those who supported the more postmodern end of the continuum with participatory actions

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supporting health improvement. This was also true of the nurses and sociologists. The lack of clarity is particularly evident in nursing where commonly used textbooks concerning the nursing care of aggregates are entitled with the term *community health* In the analysis of the interviews the grounding of the interviewees in "public health," and particularly governmental public health, supported their stronger emphasis on epidemiological frameworks for decision-making in health improvement. This finding is important for future work in the development of this concept. It raises questions about the appropriate curricula for students concerning the subject of *community health,* the processes used by community health professionals in practice and research when working with communities, and the skills those community members need to improve their own communities.

The developmental aspects of the concept of *community health* were evident from the analyses of the professional literature, the community health assessment instruments, and the interviews with experts in the *community health* field. Historically, there has been much confusion over the use of the terms "public health" and "community health." For example, the term "public health" was used by Lillian Wald as she promoted health in New York City tenements (Stanhope & Lancaster, 2000). In this example, public health was used at that time to refer to health care services provided in communities for populations at risk. This was consistent with the use of the public health for the development of community infrastructure elements such as community water and sewage systems. The concept of *public health* was narrowed after World War II as it was defined as the governmental work concerning health promotion and disease prevention for the residents of a community.

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The sociocultural context was described in the professional literature in the study through a series of events and reports that were widely disseminated. For example, the Healthy Cities/Communities initiative was promoted first in Canada and spread to Europe in the 1970s and later the United States and other areas of the world in the 1980s (Flynn, 1996). The use of the term *community health* became more widespread after that time. In 1978, the World Health Organization in the Declaration of Alma Ata defined "primary health care" with many of the same attributes as that of community and public health, further diminishing the conceptual clarity. This declaration was supported later in the World Health Organization's Ottawa Charter for Health Promotion (1986) that defined health promotion from a community development perspective. In this document, the concept of *health promotion* overlapped that of *community health.*

The lack of clarity over the meaning and appropriate uses for *community health* or "public health" was evident when the Institute of Medicine defined the mission of public health in a manner that included characteristics of the Healthy Cities/Communities model. This definition of public health as "what we, as a society do collectively to assure the conditions in which people can be healthy" (Institute of Medicine, 1988, p. 1) is much broader than the definition of public health as governmental activities and services that was more commonly used before that time. In this document the governmental role of "public health" was expanded to include aspects consistent with *community health* as used in the attributes of the professional literature in this study. These aspects included community development, population based, health promotion and disease prevention, and links to environment to improve health. The World Health Organization further confused the definition of public health by defining "primary health care" in the Declaration at

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Alma Ata as addressing a broad definition of health. This Declaration also included community involvement and development as a part of "primary health care."

The analysis of these documents indicated that while there is growing support for a blending of the meanings of *community health* and *public health,* there is also tension regarding the degree of community participation associated with both concepts. As the focus of *community health* became more "local," such as that supported in the Healthy Communities initiative and the attributes of the concept of *public health* overlapped those of *community health,* epidemiologists' view of populations led to the use of a new term, "population health." This was defined as the study of "multiple determinants of health and the patterns between them" (Kindig & Stoddart, 2003, p. 381) and was a return to the more professional "normal science" or "reductionist" view of the health of aggregates. The tension of who "owns" the community health improvement processes continues today.

The elements of the sociocultural context that were derived from the literature included a philosophical foundation of social justice for the concept of *community health* within a context of a global economy in which governments have fewer resources for health improvement and there are wide disparities in health and social resources and outcomes. The idea of being of, or for, the "community" good indicates a need for equitable distribution of resources for the group rather than the distribution in a more competitive manner for individuals. Social justice was linked in the analyzed literature to American traditions, primary health care, and public health. The World Health Organization (1998) has built many of its recommendations on the principles of social

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justice. This philosophical underpinning is important in the application of social justice in the activities associated with the concept of *community health.*

One of the difficulties surrounding the implementation of social justice principles is the increasing cost of health care worldwide and the competition for scarce health care resources. The sociocultural context surrounding community health is one in which the resources for *community health* activities have grown more scarce. This is particularly evident in governmental *community health* activities as policy decisions are based on beliefs in "individualism" rather than "social justice" (Raphael & Bryant, 2002, p. 392). Even in countries in which more socialized forms of health care delivery are established, there are decreasing funds for health care delivery in any form (Buschkens, 1990; Mooney, 2000a; Ranson, 2002). In addition, funding for governmental support of community development is concomitantly shrinking. This issue was strongly supported by several of the interviewees who discussed reductions in funding particularly for governmental health functions. Two of the interviewees discussed the impact of the "preparedness" policies that were established in response to the terrorist attack on the United States on September 11, 2001 and the anthrax threats during the same time period. They reported that these "militaristic" policies drew funding away from needed community and public health services. These sources supported the investment of policy development to redistribute funding for governmental health services and community development. The United Nations Millennium Development Goals (2005) indicate that these are key issues globally, not only in the United States.

The philosophical foundation of social justice that supports the concept of *community health* provides an underlying belief system for the activities of *community*

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health that includes an equitable distribution of resources. The widening disparities in health and social outcomes across the globe will require further analysis of the impact of this philosophical belief on the continued evolution of the concept. It is much easier to note the impact of the disparate distribution of wealth and health resources in the news media in the current age of fast global communication. Furthermore, the attribute of ecological frameworks can provide a theoretical method for the analysis of impact of these policy decisions on *community health.*

"Significance" was defined by Rodgers as the "concept's ability to assist in the resolution of problems, its ability to characterize phenomena adequately thus furthering the efforts toward the achievement of intellectual ideals." (Rodgers, 1989, p. 332). The significance of the concept of *community health* was evident in the vast body of literature available that concerns the use of the concept. There were over 13,000 articles elicited for the thirteen year period of the study before determining limits for a representative sample. Furthermore, in the "landmark" works of literature, there were only four overlapping citations within the list of 36 sources. The little overlap of landmark works raised the question that if more experts were asked, the list of landmark books may have included additional citations. The four overlapping citations also indicate a need to explore further the possible rankings of the "most important" works for research, education and practice regarding the subject of community health.

The use of *community health* in titles of various community health nursing textbooks (Clemen-Stone, McGuire, & Eigsti, 1998a; Spradley & Allender, 1996; Stanhope & Lancaster, 2000; Swanson & Nies, 1997) and the professional organization of teachers of this branch of nursing (Association of Community Health Nurse Educators)

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provided further evidence of the wide use of the term "community health." Its significance is also evident in its use in the naming of governmental agencies, such as Michigan's "Department of Community Health," and world wide initiatives, such as the "Healthy Communities" programs (Flynn, 1997). The use of *community health* in these situations provide evidence for its continued development as an important concept concerning the improvement of health in local communities.

The sociocultural context surrounding the concept of *community health* provides evidence of the importance of this concept for health improvement and community development on a global scale. Recent recommendations of the Institute of Medicine in the United States, the World Health Organization, and the United Nations support more equitable distribution of resources to reduce hunger, poverty, and ill health and to improve quality of life through better housing and equitable education programs throughout the world. These recommendations lend support for the inclusion of broad determinants of health and community development as attributes of *community health.* The evolution of the concept was evident in these recommendations, reports and community initiatives that were described in the professional literature analyzed in this study. The continued development of the evolution of the concept is needed to further clarify the ecological nature of the interplay between these broad determinants of health, community health improvement processes, and improved health of communities.

The use of *community health* was evident in the "community health assessment instruments." These instruments were designed to identify those factors that constituted a community's health. The people who determined the variables to be included in the assessment varied depending upon the philosophical beliefs of those leading the process.

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How these people applied participatory action principles would have an impact on the composition of the health planning team. The more the community members participated in the process, the more it would be expected that they would be empowered to make more decisions about the development of their own community. On the other hand, if the professionals determined the set of variables or "health indicators" to measure health improvement over time, the less participatory the process became. Schwab (1997, p. 3050) described "postmodern epidemiology" as a search for local understanding rather than universal truths." The implication of this philosophy is that the "truth" is local, rather than data driven. The concept of *community health* derived from the literature analysis included this postmodern perspective.

Conclusions Regarding Related Concepts and Surrogate Terms

The attributes that comprise the definition of the concept of *community health* and its use over time have evolved and become intermixed with other concepts such as "public health" and "population health." In most of these cases, "community health," "public health," and "population health" are either used synonymously (Association of Community Health Nurse Educators, 1993) or the meanings of the concepts overlap. The attributes of *community health* are differentiated from either "population health" or "public health" in that *community health* is a condition that is defined by the members of the community who comprise it. The attribute of participatory action supports the empowerment of the members to make decisions that support the community's development. The focus of this definition is the grass roots nature of the concept. In keeping with the "community based, participatory action" philosophy, the community members own the health improvement and development process. They work in

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collaboration with professionals of the disciplines needed to support their community health development and promote the empowerment of the community members themselves.

The changes in the use of the concept of *community health* are evident over the thirteen years of the literature sample. Although the Healthy Cities/Healthy Communities initiative and the Declaration at Alma Ata occurred before the study period, the literature sample included many descriptions of both initiatives (Awofeso, 2003; Clark, 2000; Flynn, 1996; Flynn, 1997; Gottschalk, 1996; Hancock & Duhl, 1988; Kenzer, 2000; Kickbusch, 2003; Rains & Ray, 1995). These events and subsequent documents including the publishing of the Future of Public Health (Institute of Medicine, 1988) and the Future of the Public's Health in the 21st Century (Institute of Medicine, 2003), the definition of the Essential Public Health Services (U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2003), and more recently the draft "Public Health Nursing: Scope and Standards of Practice" (American Nurses Association, 2005) all have had or may continue to have an impact on the evolving definition of the concept of *community health.* The overlapping meanings of the concepts of *public health* and *population health* with *community health* will require further clarification as educators and researchers continue to describe entities and areas of practice as "Schools of Public Health," "Community Health Nursing," "Population Health Institutes" and "Departments of Community Health" or "Public Health.

Implications of the Study

This study was designed to identify a definition of *community health* as a conceptual foundation for the development of knowledge in this subject area. Concepts

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form the content of a discipline and are used as a foundation for further inquiry (Rodgers, 2000; Toulmin, 1972). In this study, the attributes of the concept of *community health* were identified through three phases: a systematic analysis of a random sample of professional literature and landmark works from the disciplines of nursing, medicine, public health, and sociology; an analysis of six commonly used community health assessment instruments; and interviews with seven key informants who were experts in *community health* in the United States. The study questions were focused on identifying the attributes of the concept among the various disciplines, the sociocultural context surrounding its use, and use of surrogate terms and related concepts. The use of Rodger's Evolutionary View of Concept Analysis (2000) provided a research model that incorporated a systematic approach to traditional qualitative inquiry. This model enhanced the trustworthiness of the study in that a random sample of literature was selected from indexed literature that was representative of the disciplines that most often use the concept. These disciplines were identified during the initial exploration of the concept. Furthermore, the attributes and context identified in the initial literature analysis phase, were tested against the attributes identified in community health assessment instruments, and the perspectives of the key informants. Through this research, a definition of the concept of *community health* was identified. This definition can provide a foundation for future work regarding this concept. Specifically, this definition provides a rationale for decision-making for practice, health professional education and future research and the implications of this study for these areas are described in the following section.

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Implications for Practice

The definition of community health as a concept that is population based requires that the "community" be seen as a "living organism" (Fawcett, 1998; McMurray, 1999). This means that identification of health strengths, concerns and interventions must address the "community" as a whole rather than its individual members and the resources required for health improvement must address the health needs of the whole community applying principles of social justice. Using this perspective, the concept of *community health* is based on a definition that includes broad determinants of health. Housing, transportation, etc., all have a role in the promotion of the community's development and health improvement. This definition also requires a focus on health promotion and disease prevention. This means that the allocation of resources must be addressed toward these areas rather than illness oriented, tertiary care and further implies that policy development is a key intervention for community health practitioners. This was evident in the literature analysis as policy development is described in the landmark works as a "core function of public health." (Flynn, Rider, & Ray, 1991) The attributes of *community health* included in this definition are similar to those evident in the use of *public health.* One of the major differences derived from the analysis of the literature is the degree of participatory action that is applied in *public health* practices. Furthermore, in recent years, public health is being defined by the "conditions" required to keep the public healthy and the "ten essential public health services (Institute of Medicine, 2003; U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2003) These services include such functions as monitoring health status; diagnosing and investigating health hazards in the community; informing, educating, and

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empowering people about health issues; mobilizing community partnerships to identify and solve health problems; developing policies and plans that support individual and community health efforts; enforcing laws and regulations that protect health and ensure safety; linking people to needed personal health services and assuring the provision of health care when otherwise unavailable; assuring a competent public health and personal health care workforce; evaluating the effectiveness, accessibility, and quality of personal and population-based health services; researching new insights and innovative solutions to health problems (Institute of Medicine, 2003; U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2003). It is interesting that empowerment is listed as an "essential service" but was not described in the community health assessment instruments or discussed by the interviewees.

The definition of the concept of *community health* derived from the literature indicates that the specific status of *community health* is defined by community members through participatory action with philosophical beliefs of empowerment and community development. The actions to be taken to promote the health of a community would be much less specific than those defined as public health essential services in that they would be identified by the community members based on local health priorities. This also raises the question of accountability for the outcomes of the health services supporting *community health.* As described by one of the interviewees, there is no statutory requirement for accountability for local community members as there is for governmental entities. This raises a question for future study, i.e. What is the more effective service delivery model for community health improvement, data driven priority setting and services or local priority setting based on community participatory action? What would

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be the most effective system of combining both options? This is the area of research Fawcett and his group have developed in the *Community Toolbox.* This largely theoretical model includes a foundation for research in some of the community capacity building processes indicated for *community health.*

Rather than the current focus of health care services on tertiary levels of prevention or treatment of disease and/or rehabilitation, the focus of *community health* is on health promotion and disease prevention. McGinnis (2001) suggested a set of activities to "level the playing field for disease prevention and health promotion efforts: Inform the Public . . Change the Analytic Paradigm. . .Seek Stronger Incentives. . .Invest in the Science Base. . .and, Support Enlightened Leadership and Partnerships" (p. 394-395). He recommended that there is a need to raise the awareness of the public about the potential for long term health improvement if health promotion and disease prevention techniques are used. To further the development of the concept of *community health,* we need to determine impact of the outcomes of these primary and secondary prevention strategies on health improvement. There is also a need to invest more in research that promotes the scientific evidence for health promotion and disease prevention interventions, and to develop and support creative leaders who will support community system change and promote health care delivery models focused on health promotion and disease prevention. This will require those who will stand up to powerful interests who have much to gain from the status quo.

The participatory action attribute supported in the literature has major implications for the ways that health professionals work with community members. When applying the concept of *community health,* participatory action changes the

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maternalistic/ paternalistic patterns of traditional practice in which the agenda for health improvement is set by professionals. With the definition of *community health* derived from the literature in this study, the community health practice would be demonstrated by partnership and collaboration. In this manner, the professional becomes the facilitator or coach as the community members learn strategies that promote their capacity to make decisions concerning their own development. This postmodern perspective supports the philosophical underpinnings of community based, participatory action.

Another issue that crosses education, research and practice is the confusion over the use of surrogate terms for *community health.* During the summer of 2005, the American Nurses Association disseminated its revised version of Public Health Nursing: Scope and Standards of Practice. This document used the more recent Institute of Medicine report about public health as a foundation (Bekemeier, personal communication, 10/11/2005). Both of these documents define "public health" synonymously with *community health* continuing the confusion over the terms. The evidence in this study indicates there is a real difference between *community health* and *public health* particularly in the control of the decision making relating to health improvement and the statutory requirements for services and accountability. Using these terms synonymously, does not provide the clarity needed to define *community health* practice or fore future research. Toulmin (1972) described a discipline as distinguished by a set of fundamental concepts. This study was designed to provide a foundation for continued development of the concepts that concern community health improvement. There is still a need to identify the scope of the surrogate terms of "public health" and "population health" and to track the evolution of the uses of these and *community health.*

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From an empirical and pragmatic perspective, the results of this study may help to elucidate the situations in which *community health* is the more appropriate concept. The grass roots, local attribute of *community health* helps to separate it from situations in which "public health" may be used. Public health concerns the "conditions" that need to be established to keep the public healthy. Population health also overlaps with *community health*, but as defined by Kindig and Stoddart (2003), this concept includes the study of all of the determinants of health across population groups, not only in a specific community of focus. Continued research and discussion is needed to clarify further each of these and similar concepts, such as primary health care.

Finally, the sociocultural context surrounding *community health* concerns the allocation of resources. The analysis of the literature sample provided evidence for a philosophical underpinning of social justice. The application of this principle would require a focus on health policy to distribute the scarce resources available for community health development more equitably. If the focus on community health policy is on the allocation of scarce resources as described by one of the interviewees, then the scope and boundaries of each of these concepts will help to determine to what programs and interventions these scarce resources should be applied.

Implications for Health Professions' Education

There are also implications for the education of health professionals who work with population groups and/or in community settings. As described previously, textbooks used for basic nursing education are more often entitled *community health* although there are also titles that include both terms, ie. "*Community and Public Health Nursing*" (Stanhope & Lancaster, 2000) Stanhope and Lancaster (2000) have described the

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broader context of "community oriented nursing" to include those nurses working with individuals in community settings as well as those working with population groups. They also described public health nursing broadly as it was described in the recent description of the scope and standards of nursing practice (American Nurses Association, 2005). More work is needed to continue to refine these concepts and particularly to prepare nurses and other health professionals for the specific work needed to promote the health of communities. That is, taking on the very different role they assume as "participatory actors," rather than "epidemiological experts" controlling the program or research designs. Professional organizations already have supported the need for improving these types of skills (Pew Health Professions Commission, 1995; Public Health Foundation, 2005). The core competencies for "public health professionals" includes three of seven domains that are directly related to both cognitively and affectively improving skills in communication, cultural competency, and "community dimensions of practice" (pages 3-5 of 7). Furthermore, there are specific competencies related to the policy skills of front line staff.

The communication skills for "public health professionals" described in the core competencies are not entirely consistent with participatory action principles in a post-modern paradigm. Although one of the skills for a front line staff person includes "Communicates effectively both in writing and orally, or in other ways," it also states "Solicits input from individuals and organizations." "Soliciting input" is similar to "user involvement" which indicates that the professional leads the health improvement process. Although the "Community Dimensions of Practice Skills" section includes such competencies as "Utilizes leadership, team building, negotiation, and conflict resolution

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skills to build community partnerships," there is no competency related to capacity development within communities. The closest competency to one of "empowerment" is "Facilitates collaboration with internal and external groups to ensure participation of key stakeholders." Facilitating collaboration and ensuring participation of key stakeholders does not imply either community ownership or skill building within the community members. These skills must also be included in the development of students who will be working in communities with community groups.

These competencies and inconsistencies support the need to better clarify the content of community health for students in the health professions. The attributes of *community health* indicate that this content should include the evidence for expanding health promotion and disease prevention services and strategies for changing health policy in this direction. The attributes also indicate a need to show patterns of health improvement as they are related to addressing broad determinants of health within communities with philosophical underpinnings of community development, empowerment, and social justice. The core competencies and the recommended curricula begun by ACHNE in the 1990s describe the educational content of *community health.* As the concept has evolved, the need for further refinement of the curricula for baccalaureate level providers and graduate prepared specialists is also needed. The Public Health Functions Project (Public Health Foundation, 2005)began the process of differentiating the competencies needed at various levels of practice. It is important that this work continue as the concept of *community health* and related concepts continue to evolve.

The rapid growth in the 1990s of health information classifications has led to a need to further refine the classification systems that define the attributes, content and

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interventions of *community health.* The OMAHA System (Martin, 2005) and the Nursing Intervention and Outcomes Classification systems (Dochterman & Bulecheck, 2004; Moorhead, Johnson, & Maas, 2000) both include interventions and outcomes for *community health* nursing. The mapping of these interventions is already occurring through the Library of Medicine's Unified Medical Language System project (United States National Library of Medicine, 2005) and continued work is needed to best describe the concept of *community health* across information systems.

Implications for Future Research

There is a great need for continued research about the various attributes of *community health* and the impact of the sociocultural context surrounding its use. Specifically, there is a need to further define the processes concerning "community engagement," "coalition building," and "community organizing" and their impact on community development and empowerment. Research is needed to identify the best processes for promoting collaboration and/or partnership among community members and professionals and to determine how these concepts are defined.

Research is also needed to better describe the interconnectedness of the broad determinants of health and processes and outcomes of ecological models of community health programs and services. Specifically, research is needed to identify the impact of the various "determinants" that impact health. For example, we know that those who are poor have worse health outcomes. What are the various factors involved in poverty that impact health outcomes? More research is needed regarding the benefits and cost effectiveness of health promotion and disease prevention/early detection models of health care? What specific strategies are required for what would be a major shift in health

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policy focused currently on tertiary forms of health care delivery to health promotion? All of these questions affect the further development of the subject of *community health* and build on the foundational definition derived from this study.

There is little research about the ethics and philosophical issues in *community health.* For example, are there patterns in career decision-making of health professions' students who have strong beliefs in either social justice or more competitive individualism? How different are the health outcomes of programs with differing philosophical foundations, such as participatory action or those with more epidemiological designs? What are outcomes in postmodern versions of *community health* research? The influence of these philosophies needs to be more clearly explicated as they impact research processes such as the protection of human subjects. How are these processes best implemented when a "community" is the subject? There is little research concerning "community" as a living organism or the subject of a study. What are the most effective strategies for implementing "community systems change" (Fawcett, 1998)? The community health assessment instruments are a beginning attempt to describe this phenomenon. These types of research will help to identify guidelines that will inform practice and education of health professionals. These and many other possible studies provide fertile ground for continued research on *community health* issues.

The purpose of this study was to clarify the concept of *community health* to promote a clear definition to guide practice, education and research. Through this study, future directions for all of these areas have been described. The study itself could be expanded in the following ways. Future studies should include a broader group of interviewees including policy makers and community members who are not *community*

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health professionals. If *community* health is "local," it is very important to identify the "local" perspective. The interviewees should include those of various age groups and cultures to better define the many views of those using the concept. Their perspective is particularly important because of the "local," community based attributes that comprise the concept of *community* health. Furthermore, more description of community health improvement practices is needed. What is the impact of a community health assessment? Is the information generated from the process used by communities and what are the outcomes? This study could also be expanded by broadening the inclusion of community health assessment instruments used in various jurisdictions in the United States and internationally to further refine the scope of the concept of *community health* and the programs used to implement it. It would be valuable to learn more about the processes and outcomes of the use of these assessments on health priority setting and health improvement. In this way we may be more effective and efficient in community assessment and planning. Finally, it would be valuable to replicate this study over time in increments of several years to monitor the evolution of the concept of *community health* and the sociocultural trends that occurred as it evolved. The results of these types of research would support the advancement of the discipline of *community health* by further developing the concepts and body of knowledge included in it.

Summary

This study was designed to analyze the concept of *community health* in three phases. Phase I included a systematic review of the literature from the disciplines of nursing, medicine, public health and sociology that was elicited from the databases of Medline, CINAHL, Sociological Abstracts, and Academic Search Elite. A representative

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sample of literature was randomly selected from each database to reflect these disciplines. A list of landmark or classic works in *community health* was also analyzed to ensure that important documents in *community health* that may have been missed through the random selection were also included. These references were identified by four experts in *community health* that included a nurse, two physicians with special training in public health, and a sociologist. The analysis of the literature sample resulted in a conceptual definition of *community health*: *Community health* is a dynamic condition defined by its member through participatory action in partnership with professionals of disciplines identified by the community members and based on philosophical beliefs of community development and empowerment. Its focus is on health promotion and disease prevention for the entire population within it using an ecological model of health improvement and including broad determinants of health. The sociocultural context in which *community health* occurs is rooted in beliefs of social justice, yet takes place in a global economy in which wide disparities in wealth are evident and in which governments have fewer resources for community development and health improvement.

The results of Phase I of the study were then compared with six *community health* assessment instruments. The results of this phase helped to elucidate the scope and content of *community health* as well as confirm the focus of the concept on the "community" as a whole and health promotion and disease prevention and early detection of disease. A community engagement process was supported by several of the instruments. The results of the analysis of the first two phases were compared with data collected in seven key informant interviews. These data provided evidence of the need for

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clarity concerning the concept and provided further support for the "local" grass roots view of *community health.*

The methods used for this research were selected because of the philosophical belief that concepts "evolve" over time and the method for analysis must reflect this dynamism. Furthermore, Rodgers' Evolutionary Method of Concept Analysis provided a more rigorous sampling framework than earlier methods of concept analysis. Through this research, the concept of *community health* has been more systematically defined. It provides a "state of the art" description of the concept that can be used as a foundation for practice and policy development, curriculum planning for health professions' students and as a foundation for future research about *community health* processes and outcomes. There is much work to be done, but this study provides a sound basis for future work concerning *community health.* As Clark (1999) wrote: "No one person has all the world's wisdom. People everywhere share small pieces of it whenever they exchange ideas" (p. 19). It is hoped that this analysis of the concept of *community health* will contribute to the exchange of ideas about this important area of health and health care.

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Appendices

Appendix A. Coding Form

Analysis of the Concept of Community Health
Coding Notes

Reference Cited

Key words

Label

Attributes

Sociocultural context of the use of the concept

Antecedents (situations that precede an occurrence of the concept)

Consequences (events following the situation)

Other contextual information

References

Related concepts and Surrogate Terms

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Appendix B. Letter of Request for Landmark Works

University of Wisconsin – Milwaukee
College of Nursing

March 9, 2004

Inside address

Dear (name)

I am currently a doctoral candidate in the College of Nursing at the University of Wisconsin – Milwaukee. My dissertation research concerns community health as a concept and is under the direction of Beth L. Rodgers, PhD, RN, FAAN. Dr. Rodgers has designed a method of concept analysis that involves analysis of the use of a concept in the professional literature and practice.

I will conduct an analysis of the literature of public health, medicine, nursing, sociology, and urban studies and compare the results with community health assessment instruments. I will also be interviewing professional experts in the field to test the applicability of the derived definition to practice. You have been identified as an expert because of your (*insert program of research or practice*.) My hope is that a systematic analysis of the literature and uses of the concept of community health will aid in providing a foundation for further development in research, practice, and in academia.

In the first phase of my research, I will analyze a random selection of the professional literature concerning community health. As an extension of the sample, I am seeking the advice of experts in identifying landmark works and/or essential reading to include in the analysis. I would appreciate your recommendation of a brief list of works that you feel should be included in the study because you consider them to be classics or essential reading in the field of *community health*. A response form and stamped envelope is enclosed for your convenience.

Thank you in advance for your assistance with this research. I look forward to your response and sincerely appreciate your work in this arena.

Sincerely yours,

Mary Jo Baisch, M.S., R.N.

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Appendix C. Interview Guide

Analysis of the Concept of Community Health
Interview Guide

I. Introduction

As you know from the consent form that you signed, the purpose of this interview is to describe your perception of the definition and uses of the concept of *community health*. I will ask some very general questions and there are no right or wrong answers. I am interested in your beliefs and opinions. I want to remind you that all information you share is confidential.

II. Interview Guide and Potential Probing Questions

a. Please tell me in your own words how you would define *community health*?

   Probes:

   i. When you think of the words *community health*, what do they mean to you?
   ii. Describe what you think of as the characteristics or attributes of *community health*.

b. When you think of the concept of *community health*, what other words or concepts come to mind?

   Probes

   i. Are there other words or terms that you use instead of the words community health?
   ii. How do you differentiate between these terms?

c. In what kinds of situations would you use the concept of community health?

   Probes

   i. What are the events that would indicate the concept of community health?
   ii. What place does community health have in the health care delivery system?

d. Is there anything else you think I should know about the concept and its use?

Adapted from Kersbergen, A. L. 1996 and Sadler, J. J., 1985

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Appendix D. List of Landmark Works

**Landmark Works Solicited for the Study:
Analysis and Observation of the Concept of Community Health 2004-2005**

APEX/PH Work Group. (2001). *Mobilizing for Action through Planning and Partnerships (MAPP): A Strategic Approach to Community Health Improvement.* Washington D.C.: National Association of County and City Health Officials.

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National Association of County and City Health Officials. Mobilizing for Action through Planning and Partnerships (MAPP), MAPP Field Guide.

National Association of County and City Health Officials. (1991). *APEX/PH: Assessment Protocol for Excellence in Public Health.* Washington D.C.: National Association of County Health Officials.

Peterson, D. J., & Alexander, G. R. (2001). *Needs Assessment in Public Health: A Practical guide for Students and Processionals.* New York: Kluwer.

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Appendix E. List of Coding Categories and Subcategories

Attributes	Attributes Interventions
Providers	Art therapy Community health leadership Community health nurses Community health workers Cultural competence Dentistry Curriculum Discipline Education Interdisciplinary/Multidisciplinary Medicine Nursing Nutrition Occupational health Parish nursing Provider education Providers Psychology Social Services Sociology Social Welfare Urban Planning Role Worksite Job stress Community health centers Public health
Population	Aging Assets ATODA Child abuse Children Children with special health care needs Community outreach workers Homeless Disability Domestic violence Elderly Health literacy Healthy Start HIV

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	Marginalized groups Minority health/ Racial and ethnic minorities Population/population based Poverty Rehabilitation Rural School health Stigma Substance abuse Women's health Youth
Health Policy	Healthy systems Community Nursing Centers
Significance	Use References Significance
Interventions	Access to care Advocacy Home treatment Planning Art therapy Assets Assurance ATODA/substance abuse Capacity building Care planning-planning Case finding Case management Change Collaboration Communicable disease control Community assessment Community based Community development Community health care Community mental health Computer networking/technology Consultation Content Coordination Cultural competence Dental/Fluoridation Domestic violence Education Empowerment Environment

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	Family Planning Growth and development Health care Health education Health literacy Health promotion Healthy Start HIV Housing Institutional support Interventions Lead Nutrition Occupational health Outreach Parenting Participatory action research Partnerships Prevention Primary care Primary healthcare Public health threats Recovery Recreation Rehabilitation Relationships Resilience Risk Safety Sanitation School health Screening Service learning Social marketing Social medicine Social services Violence/anger management
Place	Australia Great Britain Health care sites Health systems Hospitals International Rural Setting United States

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Research	Literature review Mortality Research/research strategies Survey research
Economics	Economics Health insurance
Philosophy	Categorical approaches Community based Community development Assets Health Ecological model Ecology theory Empowerment Ethics Participatory action Partnerships Philosophy Population based Post modern epidemiology Primary health care Reductionist views Social justice Social medicine Theoretical frameworks
Sociocultural context	Antecedents and antecedents/interventions Change Consequences and consequences/interventions Computer networking History Morbidity Outcomes Public health threats Recovery Risk Stigma Technology
Related concepts	Related concepts

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Appendix F. Comparison of health indicators in selected community health assessment instruments.

	CHIP Model	MAPP	PATCH	IPLAN*	Community Tool Box	CHUNAS	Total
Demographic factors	1			1	1		3
Age	1	1		1		1	4
Race/ethnicity	1	1		1		1	4
Vulnerable groups	1	1		1			3
Migrants	1	1					2
Homeless	1	1					2
Non-English speaking	1	1					2
Rural population				1			1
Socioeconomic characteristics				1			1
Education	1	1		1		1	4
Median and per capita household income	1	1		1		1	4
Adults/children below the poverty	1	1		1			3
Unemployment rate	1	1		1		1	4
Single-parent families	1	1		1		1	4
Receiving Medicaid				1		1	2
Uninsured	1	1		1		1	4
Receiving food stamps				1		1	2
Health Status	1						1
Maternal and child health/Parenting		1		1			2
Entrance into prenatal care in 1st trimester		1		1			2
Adolescent pregnancy rate		1		1			2
Very low birthweight		1					1
Births to teens	1	1		1			3
Child abuse	1	1					2
Smoking during pregnancy				1			1
Infant, child growth				1			1
Child neglect	1	1					2
Social and mental health		1				1	2
Psychiatric admissions		1		1			2
Mortality	1	1					2
Excess non-white deaths				1			1
Life expectancy at birth				1			1
Infant, child, neonatal	1	1					2
Motor vehicle crashes	1	1	1				3
Work-related injuries	1						1
Suicide	1	1	1	1			4
Homicide	1	1	1	1			4
Ephysema			1				1
Lung cancer	1	1	1	1			4

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Breast cancer	1	1		1			3
Cardiovascular diseases	1	1	1	1			4
Drug related deaths				1			1
All causes		1					1
All and all other cancers		1	1	1			3
Unintentional Injuries		1	1	1			2
Years of Productive Life Lost (YPLL)		1		1			2
Motor vehicle crashes		1		1			2
Cervical cancer		1		1			2
Colorectal cancer		1		1			2
Chronic obstructive lung disease		1	1				2
Chronic liver disease and cirrhosis		1		1			2
Diabetes mellitus		1	1				2
Pneumonia/influenza		1		1			2
Stroke		1	1	1			3
Illness and injury		1		1		1	3
All causes	1						1
Morbidity		1		1		1	3
Infectious disease		1		1			2
AIDS	1	1		1			3
Tuberculosis	1	1		1			3
Syphilis	1	1		1			3
Gonorrhea		1		1			2
Chlamydia		1		1			2
Bacterial meningitis cases				1			1
Hepatitis A cases				1			1
Hepatitis B cases				1			1
Hepatitis C				1			1
Health Risk Factors		1				1	2
Childhood immunizations	1	1		1		1	4
Adult immunizations	1	1				1	3
Smoking	1	1		1		1	4
Seat belt use		1	1				2
Bicycle helmet use		1				1	2
Condom		1					1
Mammography		1				1	2
Hypercholesteremia				1			1
Hypertension			1			1	2
Pneumonia	1	1					2
Obesity	1	1	1			1	4
Exercise/sedentary lifestyle		1	1			1	3
Nutrition		1				1	2
Binge/chronic drinking		1	1			1	3
Illegal drug use		1				1	2

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Environmental health indicators		1				1	2
Rabies in animals: number of cases		1					1
Workplace hazards - Percent of OSHA violations		1					1
Food safety - foodborne disease: rate per total population (CHSI Report)		1		1			2
Lead exposure - Percent of children under 5 years of age who are tested and have blood levels exceeding 10mcg/dL		1					1
Waterborne disease: rate per total population		1					1
Fluoridated water - percent total population with fluoridated water supplies		1		1			2
Air quality indoor/outdoor		1		1			2
Soil toxicity		1		1			2
Water that supports beneficial uses		1		1			2
Health Care Resource Consumption						1	1
Health Resource Availability		1				1	2
Per capita health care spending for Medicare beneficiaries		1					1
Medicaid eligibles to participating physicians		1		1			2
Licensed dentists: rate total population		1		1			2
Licensed primary care physicians: rate total population		1		1			3
Licensed hospital beds: total, acute, specialty beds; rate total population (and occupancy rate)		1					1
Proportion of population without a regular source of primary care (including dental services)		1		1			2
Local health department full-time equivalents employees (FTEs): number per total population		1					1
EMS vehicles				1			1
Total operating budget of local health department: dollars per total population		1					1
Functional Status	1					1	2
Self-reported health status	1	1				1	3
Average number of sick days/month		1				1	2
Recent poor health	1	1				1	3
Quality of life		1					1
Satisfied with the health care system	1	1				1	3
Satisfied with the quality of life in the community	1	1				1	3
Proportion of parents in the PTA		1					1
Number of openings in child care facilities for low income families		1				1	2
Number of neighborhood crime watch		1				1	2

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areas							
Civic organizations/association members per 1,000 population		1					1
Percent of registered voters who vote		1					1
Occupational Health				1			1
Sentinel Events		1	1	1			3
Measles	1	1					2
Mumps		1					1
Rubella		1					1
Pertussis		1					1
Tetanus		1					1
Late stage diagnosis cancer – cervical		1		1			2
Late stage diagnosis cancer – breast		1					1
Death rate for work-related injuries		1					1
Syndromes due to unusual toxins or infectious agents (i.e., smallpox, anthrax)		1					1

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Curriculum Vitae

MARY JO BAISCH

PLACE OF BIRTH Grand Rapids, MI

EDUCATION

Mercy College of Detroit	B.S.N.	1977
University of Michigan	M.S.	1980
University of Wisconsin-Milwaukee	PhD	2006

Dissertation Title: Analysis and Observation of the Concept of Community Health

PROFESSIONAL EXPERIENCE

Assistant Professor 2006-present
University of Wisconsin- Milwaukee
Milwaukee, Wisconsin

Director, Institute for Urban Health Partnerships 1999 to 2005
Clinical Assistant Professor
Colleges of Health Sciences and Nursing
University of Wisconsin-Milwaukee

Staff Nurse (Part-time) 1993 to 1998
Prenatal Care Coordination Program
Sinai Samaritan Medical Center
Milwaukee, WI

Executive Director 1989 to 1990
Sixteenth Street Community Health Center
Milwaukee, WI

Director 1984 to 1988
Teen Pregnancy Service of Milwaukee
Medical College of Wisconsin
Milwaukee, WI

Adjunct Clinical Assistant Professor 1984 to 1990
University of Wisconsin-Milwaukee
Milwaukee, WI

Assistant Professor, Instructor 1982 to 1984
School of Nursing

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University of Wisconsin-Milwaukee
Milwaukee, WI

Clinical Nurse Specialist 1980-1982
University of Michigan Medical School
Department of Family Medicine
Ann Arbor, MI

Staff Nurse 1977-1980
St. Joseph Mercy Hospital
Ann Arbor, MI

Instructor 1979-1982
Washtenaw Community College
Ann Arbor, MI

HONORS

Doctoral Fellowship in Armenia March 2003
Center for International Health, Milwaukee, WI

Nurses Foundation of Wisconsin Dissertation Award 2002

Provost's Merit Award 2002

Phi Kappa Phi Graduate Honor Society 2000

Sigma Theta Tau International, Eta Nu Chapter, Graduate Scholarship 1999

Nancy Wright Fellowship, UWM School of Nursing 1997-1998

UWM School of Nursing Teaching Award 1992

Wisconsin Association for Perinatal Care, Volunteer Awards 1989, 1990

Sigma Theta Tau - Rho and Eta Nu Chapters 1980-present
(National Honor Society for Nursing)

McCauley Award for Leadership in Nursing 1977
Mercy College of Detroit

1-16-06

Major Professor 1/16/06

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