CHAPTER 25

Community Development for Population Health and Health Equity

Stephen Fawcett, PhD • Jerry Schultz, PhD • Vicki Collie-Akers, PhD • Christina Holt, MA • Jomella Watson-Thompson, PhD

LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1. Describe key concepts of community health and development such as community development, collaborative action, and community/population health.
2. Differentiate models of community organization practice (i.e., locality development, social planning, social action).
3. Describe three models of community health promotion.
4. Describe the phases and processes of the framework for collaborative action.
5. Discuss the evidence for community development approaches.
6. Understand and apply core competencies for a community health and development workforce.

KEY TERMS

capacity building
community development
community development workforce
community health
health equity
population health

Citation: Fawcett, S.B., Schultz, J., Collie-Akers, V., Holt, C. and Watson-Thompson, J. (2016). Community development for population health and health equity. (pp. 443-460). In P. Erwin and R. Brownson (Eds.), *Scutchfield and Keck's Principles of Public Health Practice*. 4th edition. Boston, MA: Cengage Learning.

INTRODUCTION

Communities throughout the world—and the people and settings that comprise them—are a primary resource and locus for public health action. In this multilevel work, collaborative action at the community level is the fulcrum between efforts addressing individuals and relationships and those at the level of broader systems. This chapter outlines key concepts in community development for health and health equity. It also offers models and frameworks and several case examples of community health development efforts in diverse contexts of public health practice.

COMMUNITY HEALTH AND ITS DEVELOPMENT

The work of assuring conditions for health and well-being occurs in and with communities; that is, those who share a common place, interest, and/or experience. It occurs in a variety of places—cities and towns, urban neighborhoods, and rural villages. This work engages those with shared interests—for example, people concerned with the incidence of infant mortality or childhood obesity or in addressing health disparities and the conditions that produce them. **Community health** development engages those with diverse experiences—such as those experiencing violence or exposure to hazards as well as those with technical expertise in community health assessment, planning, and intervention. Exhibit 25-1 describes what **community development** actually looks like at the ground level.

Some Key Concepts of Community Health and Development

Community development is the process of people working together to affect locally determined issues/goals and the conditions that affect them.[1] An enduring theme is participation of local people—those with experiential and technical knowledge—in changing the environment and broader conditions.[2] An early United Nations report defined community development similarly, as the "process by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social, and cultural conditions of communities...."[3] The U.N. also stated that a key role of intermediary organizations is to link people of the community with outside resources to advance locally determined efforts.[4] Thus, community development is both process (engagement of people and groups in collaborative action) and product (changed conditions and improved outcomes related to locally determined goals).

In the context of public health practice, the aim of community development is collaborative action for community health improvement.[5] Community/population health improvement requires the engagement of:

a) multiple agents of change (e.g., community residents, local and state organizations),
b) working together across sectors (e.g., governmental units, businesses, faith communities, health and human service organizations),
c) over time (e.g., multiple years), and
d) across ecological levels (e.g., individuals, relationships, community).[6]

Community development is closely related to the work of health promotion at the community level.[7,8] Health promotion refers to the "process of enabling people to increase control over and to improve their health."[2] An ecological model of health promotion sees **population health** as an interaction among behavior and personal and environmental factors at multiple ecological levels.[9] As a process of community development, health promotion is ongoing and gradual—unfolding over time, not a one-time response to a crisis or outbreak. The product of health promotion is a continuum of outputs and outcomes, including:

a) development activities (e.g., planning, training, and capacity building);
b) targeted action (e.g., intervention, advocacy for policy changes);
c) community and systems change (e.g., environmental and policy changes related to targeted goals and objectives);
d) widespread behavior change; and
e) improvement in population-level outcomes (e.g., incidence and prevalence of childhood obesity or violence).[5,6,10]

Social justice and equity demand the elimination of health disparities: going beyond improvement in community-level indicators for the overall population to seek reductions in differences for marginalized groups. Health disparities/inequalities refer to potentially avoidable differences in health (and associated risks) between groups of people who are more and less advantaged socially.[11] A human rights perspective calls for all people and communities to have the right to conditions conducive to health and well-being (e.g., access to healthy food and clean water, education and health services; protection from hazards) and meaningful participation and power in influencing those conditions (e.g., through political rights, fully functioning civil society).[11,12]

The World Health Organization (WHO) reminds us of what is required for health for all: "Without peace and justice, without enough food and water, without education and decent housing, and without providing each and all with a useful role in society and adequate income, there can be no health for the people, no real growth and no social development."[13]

Assuring conditions for **health equity** requires attention to social determinants of health (SDH).[14,15] The WHO conceptual framework for action on social determinants[16] outlines three levels of determinants that interact to affect equity in health and well-being:

a) structural drivers (e.g., taxation, environmental protections and policies; governance; societal norms);
b) social position and stratification determinants (e.g., social class, race/ethnicity, education, income); and
c) intermediary determinants (e.g., material circumstances, behaviors, and biological factors; psychosocial factors; health care system).

(See Chapter 3 for more detail on social determinants of health.)

Community development approaches for health and health equity seek to change personal and environmental factors related to the priority issues/goals by, for instance, providing information and services, modifying access and opportunities/exposures, and assuring supportive policies. Community development approaches also seek to change the mechanisms by which social determinants produce inequities. They aim to reduce:

a) differential exposure to intermediary factors (e.g., through policies that reduce exposures to hazards, and assure access to healthy food and decent housing);
b) differential vulnerability to health-compromising conditions (e.g., by enhancing opportunities for early childhood education, training for jobs that pay a sufficient wage); and
c) differential consequences (e.g., assuring access to quality health services for everyone).

When a place has these qualities, WHO refers to it as a healthy community—whether a healthy city, municipality, or village.[13]

EXHIBIT 25-1 What does the Work of Community Development for Health Look Like?

Media coverage of community health problems shows our city to be lagging far behind others. Childhood obesity and chronic diseases are rising, poverty is high, educational outcomes are low, and access to health services is limited, and some disadvantaged groups are particularly affected. The mayor convened a group—the Healthy City Partnership—to engage community members and organizations in addressing these issues. The county health department agreed to serve as the lead organization—engaging governmental units, schools, health and human service organizations, community organizations, advocacy groups, and local community foundations. Community assessments—using existing data sources, focus groups, and surveys—helped determine the level of particular problems/goals as well as community assets and top concerns. The Partnership's organizational structure reflected its goals: an overall Community Advisory Board and four targeted action committees, including healthy nutrition, physical activity, poverty, and access to health services. Action planning for each goal area (and related committee) helped establish priority strategies and opportunities for assuring environmental conditions needed to meet targeted outcomes. Open monthly meetings—held in a trusted community center—assured space for people and organizations to plan, communicate, and support collaborative action. A monitoring and evaluation system enabled the group to document and systematically reflect on its activities and outcomes, be accountable, and make needed adjustments.

MODELS OF COMMUNITY DEVELOPMENT FOR HEALTH

This section leads with several prominent models of community development and health promotion from the fields of community organization and public health. It concludes with a framework for collaborative action for population health and health equity.

Models of Community Organization Practice

Rothman and colleagues[16] differentiate three distinct models of community organization that can be applied to population health improvement: locality development, social planning, and social action (see Table 25-1). The model of *locality development* recognizes the importance of engaging indigenous people, local residents and groups, as the community experts who are well positioned to inform selection of priority goals and development of interventions that fit culture and context. It focuses on building the capacity of individuals (e.g., residents) and groups (e.g., community organizations, nongovernmental organizations) to support community action. Bringing local people together to identify a common vision and shared goals for community health and development is seen as critical for community ownership and sustainability of efforts. The *social planning* model is an expert-based approach for addressing complex community health and development issues.[16] It focuses on providing technical solutions through the development and implementation of plans and policies. The premise is that efforts to influence systems through the community development process should be guided by individuals with established relationships in the community (e.g., elders, trusted leaders) and those with

TABLE 25-1 A Comparison of Three Models of Community Organization Practice

Locality Development	Social Planning	Social Action
Engage local residents and groups	Convene professionals and experts	Mobilize those experiencing the problem
Build capacity to support community action	Develop technical solutions through planning	Ensure disenfranchised groups are heard
Create common vision and shared goals	Focus on getting results	Social justice is a key value

professional expertise and linkages with those systems (e.g., urban planners, agency administrators).

The *social action* model focuses on mobilizing populations and groups experiencing disparities or inequalities in efforts to improve health and development outcomes. It often involves organizing disenfranchised groups to ensure their vision, voice, and power in addressing issues of social injustice and inequities.[16]

Some Models of Community Health Promotion

Healthy Cities and Communities Model

The Healthy Cities and Communities framework was developed by the World Health Organization's Healthy Cities program.[17] It promotes locally determined, comprehensive strategies to enhance overall health and well-being of residents—physical, mental, and social.[13] The Healthy Cities framework provides a step-by-step participatory process for prioritizing and addressing issues, including:

a) getting started (e.g., knowing the context by conducting community assessments);
b) getting organized (e.g., developing a community health plan that summarizes the vision and goals of the project); and
c) taking action (e.g., encouraging community participation; engaging multiple sectors and levels).

Mobilizing for Action through Planning and Partnerships (MAPP)

This approach was codeveloped by the National Association of County and City Health Officials (NACCHO) and the U.S. Centers for Disease Control and Prevention (CDC).[18] MAPP has six phases that structure the process:

1) organizing for success;
2) visioning;
3) assessing (i.e., using a community themes and strengths assessment, a local public health system assessment, a community health status assessment, and a forces of change assessment);
4) identifying strategic issues;
5) setting goals/strategies; and
6) conducting an action cycle.

The planning/implementation/evaluation cycle continues until the community achieves its vision; it then generates a new vision to work toward.

Healthy People 2020 MAP-IT Framework

This is intended to help guide implementation efforts related to achieving health objectives for the nation.[19] The MAP-IT process begins with the **M**obilization of individuals and groups, typically through a coalition or group of individuals and organizations that assemble to address issues in the community. Next, coalition members and community stakeholders work together to **A**ssess the needs and resources/assets present in the community. Based on the assessment, community problems and goals are identified and prioritized. Then, a strategic **P**lan is developed that specifies measurable objectives, which serve as indicators of change and improvement. The plan also identifies clear strategies and action steps necessary to support attainment of the objectives. To **I**mplement the plan, coalition members and key stakeholders work collaboratively to facilitate changes in the community. **T**racking is an ongoing part of the process: data are collected, analyzed, and reviewed to evaluate progress and make adjustments. For tools for implementing MAP-IT, Healthy People 2020 offers links to the Community Tool Box and other resources. (These tools can be accessed at https://www.healthypeople.gov by searching "Mobilize.")

Framework for Collaborative Action for Population Health and Health Equity

The Institute of Medicine's (IOM) report on *The Future of Public Health in the 21st Century* offered a framework for collaborative public health action in communities.[5,10] Figure 25-1 displays an adapted version of this framework for population health and health equity;[6] it includes five phases in this iterative process (see A–E in Figure 25-1), along with 12 associated community development processes. These five phases illustrate a path toward community health improvement—from assessing, prioritizing, and planning, to implementing targeted action, changing conditions and systems, achieving widespread change in behavior, and to improving population health outcomes.

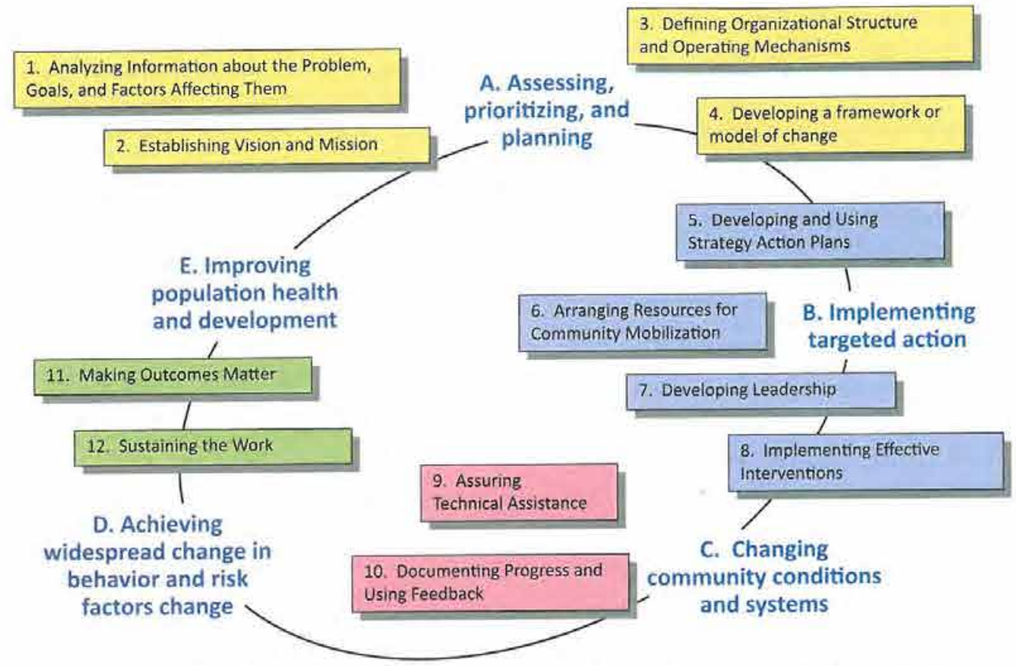

FIGURE 25-1 Framework for Collaborative Action for Population Health and Health Equity, and Associated Community Development Processes

Adapted from the "Framework for collaborative public health action," as cited in The Future of the Public's Health in the 21st century.

As referenced in Table 25-2 and outlined in the Community Tool Box (accessed at http://ctb.ku.edu by clicking on the "Help Taking Action" and "Best Change Processes" links), 12 processes are often associated with promoting community health and development.[6,8,20–22]

EVIDENCE BASE FOR COMMUNITY DEVELOPMENT APPROACHES

Do community development approaches work in bringing about community/system change and improvement in population-level outcomes? Under what conditions are changes in communities and systems sufficient to improve population-level outcomes? These are reasonable questions that are easier to ask than to answer.

Evidence Base for Bringing about Community/System Change

The underlying principles of community health[2] and frameworks for collaborative public health action[5] suggest that broad and comprehensive interventions (i.e., multiple community/system changes) are needed to effect widespread behavior change and improvement in population-level outcomes. Systematic reviews, such as the *Guide to Community Preventive Services*,[23] recommend more comprehensive interventions. Community development approaches—including community mobilization and collaborative planning and implementation—are seen as a way to change conditions in a comprehensive and sustainable way.

There is a modest evidence base for community development processes associated with changes in communities and systems.[22] Since randomized trials—in which some communities engage in community development approaches and others do not—are typically not possible, this evidence is based largely on quasi-experimental designs and the logic of multiple case studies.[24] Using a common measurement system to detect instances of community change (i.e., new or modified programs, policies, and practices), we can look for the strength and prevalence of association between particular development processes—such as action planning—and related accelerations in the rate of community change.[20,25] As noted in the framework for collaborative action (see Figure 25-1), there is modest evidence for some promising community development processes, for instance: analyzing problems and using data to set priorities for targeted action;

TABLE 25-2 Processes Associated with Promoting Community Health and Development

1. **Analyzing information about the problem or goal and factors affecting them**—This enables collaborative efforts to focus on specific goals, risk/protective factors, and targets and agents of change.
2. **Establishing a clear vision and mission**—More focused community efforts are associated with higher rates of change than more diffuse efforts working on multiple outcomes.
3. **Defining an organizational structure and operating mechanisms**—These enhance opportunities for community participation and engagement; they help create a cohesive environment for working together to strengthen implementation and help assure sustainability.
4. **Developing a framework or model for change**—By conveying a presumed pathway, they help guide planning, action, and evaluation phases of the work.
5. **Developing and using strategic and action plans**—Identifying specific community changes to be sought in each relevant sector and who would do what to bring them about has been consistently followed by increases in rates of community change.
6. **Arranging for community mobilizers**—Community organizers help assure better implementation of community-determined action plans than when change efforts rely solely on volunteers.
7. **Developing leadership**—Distributed leadership can protect against the adverse effects of loss of leadership that are typically associated with decreased rates of community change.
8. **Implementing effective interventions**—Collaborative partnerships aim to assure selection and full implementation of evidence-based practices while tailoring interventions to the local context.
9. **Assuring technical assistance**—Training, technical support, and consultation are often needed to build local capacity for what key practices to implement, and under what conditions.
10. **Documenting progress and using feedback**—Documentation and feedback provide information that permits ongoing learning, adjustments, and accountability in the effort.
11. **Making outcome matter**—Contingencies, such as bonus grants for high rates of change and outcome dividends for improvement in population-level outcomes, assure incentives for actual progress.
12. **Sustaining the work**—Improvement in population-level outcomes often requires more time than is funded by external funding agents, making it critical to sustain interventions and the efforts that assure them.

developing leadership and assuring technical assistance; developing and using strategic action plans to guide action; implementing effective interventions that fit the local context; and documenting progress and using the information for accountability and making adjustments.[6,22,26,27,28,29,30,31]

Evidence Base for Improvement in Population-level Outcomes

Community partnerships aim to bring about changes in conditions, such as environmental and policy changes, so that they can effect widespread behavior change (e.g., increased healthy eating, physical activity, reduced tobacco use) and improvements in population-level outcomes (e.g., reduced BMI, incidence of cardiovascular diseases and diabetes). Some recent research suggests that to effect population-level outcomes, community/system changes need to be of sufficient amount and intensity—i.e., strength of intervention strategy, duration, and reach.[32,33]

However, the evidence is mixed as to how well community partnerships improve outcomes at either the level of behavioral risk/protective factors or population-level health outcomes.[34] Some systematic reviews reported that from 9 to 44 percent of the reviewed studies showed improvements that could in some way be attributable to the initiative.[35,36] One plausible explanation is that effect sizes with a whole community or population (e.g., with all children in a city) will likely be much smaller and harder to detect than for more highly specific interventions involving a targeted group (e.g., 50 children enrolled in a school intervention). When the community (not individuals) is the unit of analysis, it is less feasible to engage enough communities in a study (i.e., perhaps 8–10 minimally, for each condition); and this makes it unlikely that statistical analyses will have enough power to detect small differences. The outcomes may take longer to emerge when implemented by community members; yet, most studies are five years or less in duration.

There is broad agreement that more evidence is needed. Yet, there is still a long way to go in producing strong evidence for the community development approach. We need greater support for comprehensive multicommunity studies, improved research designs, and deeper focus and improved analysis that can lead to better understanding of the community development processes that contribute to changes in conditions sufficient to "tip" population-level improvement. Until that time, the logic of multiple case studies can help us address these gaps in evidence- and practice-based knowledge.

THREE CASE EXAMPLES OF COMMUNITY DEVELOPMENT APPROACHES IN PUBLIC HEALTH PRACTICE

This section describes three case studies of community development efforts, each featuring a different approach in public health practice: community health planning and improvement efforts; collaborative partnerships for population health and health equity; and community-based participatory research. Each approach is illustrated with a specific case example with which the authors have been engaged.

Case Example 1: Community Health Planning and Improvement

Background and Context

Accreditation standards for local, state, and tribal health departments, as well as the Patient Protection and Affordable Care Act, call for improved approaches to community health assessment and implementation of planned improvements. These are consistent with the core functions and essential services of public health.[5, 37–39] There are a number of prominent models of community health improvement; they include the MAPP Framework[40] of the National Association of County and City Health Officials (NACCHO/CDC), and those of the Catholic Health Association[41] and the Association for Community Health Improvement[42] (ACHI). This section offers a case example of a community health improvement effort grounded in the Institute of Medicine's framework for collaborative action for population health and health equity. This work began in 2011 and is led by the Lawrence-Douglas County (Kansas) Health Department (LDCHD), with support from the University of Kansas' Work Group for Community Health and Development.

Core Practices for Community Health Planning and Improvement

This section outlines key implementation tasks for community health planning and improvement efforts based on a report to the CDC on core practice areas.[43] Each of these 11 practices—grounded in the community development approach—is illustrated with implementation examples from the community health improvement effort led by the LDCHD.[44]

1. **Assure shared ownership of the process among stakeholders**. Determining stakeholders' interests and establishing working agreements with clear roles and responsibilities help set the conditions for success. For instance, in the LDCHD effort, the Health Department spearheaded a comprehensive community health assessment. The dual aim was to promote the public's health and to meet NACCHO accreditation standards for a local health department. It engaged a variety of key community stakeholders, including the United Way of Douglas County, the Douglas County Community Health Improvement Partnership, Lawrence Memorial Hospital, Heartland Community Health Center, and the Douglas County Community Foundation.
2. **Assure ongoing involvement of community members**. Seeking involvement of community members and groups through the entire process—from assessment through planning and implementation—is critical for successful efforts. To do so, it is important to make participation and involvement as easy as possible. More than 1,500 community members were involved in the LDCHD community health improvement effort, including: respondents to surveys distributed online and in dozens of locations; participants in focus groups held in community centers, neighborhoods, and places of worship; those in key informant interviews; participants in a Local Public Health System Assessment; and a health-related Photovoice project engaging local youth.
3. **Use small area analysis to identify communities with health disparities**. This method, also known as "spot mapping," helps identify communities with disproportionate unmet health needs in specific geographic locations.[45] This involves geo-mapping of the incidence and prevalence of health issues to help identify places experiencing health disparities. In the LDCHD community health improvement effort, small area analysis was

used to better understand how poverty and outcomes, such as emergency department utilization for particular health conditions, were concentrated in specific areas of the county.

4. **Collect and use information on social determinants of health**. Collecting information related to social determinants of health (e.g., income, education, housing)—and addressing social determinants in the improvement plan—is critical to meaningful and long-lasting improvement efforts. In the LDCHD community health improvement effort, data were collected on rates and concentrations of poverty and educational attainment, and the community health improvement plan set poverty and job creation as a priority issue.
5. **Collect information on community assets**. Community assessment includes working with local partners to identify available community assets and resources for addressing prioritized community needs. In the LDCHD effort, community members identified more than 90 community assets through focus groups and interviews, including the local hospital, public schools, local service agencies, the health department, parks and recreation, local universities, faith communities, mental health center, the United Way, government agencies, the transit system, and features of the built environment.
6. **Use explicit criteria and processes to set priorities.** Priority setting for action involves establishing agreed-upon criteria such as evidence of effectiveness and fit with the local context.[8] It also involves identifying processes, such as community involvement in ranking, to inform prioritization of issues to be addressed in the community health improvement plan. In the LDCHD effort, results from each assessment method were carefully reviewed to find convergence, and a series of local forums were convened for community members to provide input on the results. Community members were invited to participate in priority setting. Five priority issues were chosen to be addressed by the plan: access to health services, healthy foods, mental health, physical activity, and poverty/jobs.
7. **Assure shared investment and commitments of diverse stakeholders**. Shared investment in community health improvement efforts requires shared responsibility. This includes pledges of financial and human resources for implementation of prioritized strategies from stakeholders in different sectors of the community, such as from government, schools, and health organizations. In the LDCHD effort, many community organizations are helping with implementation of parts of the community health improvement plan. For instance, the United Way of Douglas County has encouraged grantees to report on how they are contributing to implementation of the improvement plan, and the LDCHD has funded new positions to support implementation of the plan.
8. **Participatory monitoring and evaluation of CHI efforts**. In a participatory evaluation approach, stakeholders are involved in identifying indicators of success for each community-determined goal area. This helps to assure measures for accountability—and information for quality improvement—that are accurate, feasible to collect, and sensitive to the context. In the LDCHD effort, community stakeholders from different organizations were trained to systematically document accomplishments related to the community health improvement plan using an online documentation and support system,[46] and to use those data for sense-making, making needed adjustments, and accountability for achieving progress.
9. **Collaborate across sectors to implement comprehensive strategies**. Engaging diverse stakeholders from various sectors—including government, business, education, health, human services, and faith communities—helps ensure implementation of comprehensive strategies for health improvement. In the LDCHD effort, diverse stakeholders have been engaged throughout the process. Continuous communication and outreach efforts are in place to engage partners from all relevant community sectors.
10. **Establish oversight mechanisms**. Once a community health improvement plan is developed, it is important to establish a governance structure and procedures for monitoring effective implementation of the plan. This should include reviewing data periodically and communicating progress to different stakeholders. In the LDCHD effort, the steering committee meets periodically to review progress on implementation of the plan.
11. **Create formal public reporting processes**. Public reporting assures transparency and accountability to the community. It can help raise awareness and build public support for collaborative public health action. In the early implementation of the LDCHD effort, focus groups with community partners were used to assess satisfaction with progress on each prioritized goal area and to obtain community recommendations for improvement.

These steps—from early and ongoing engagement of community members to public accountability—reflect a community development approach to the work of community health improvement.

Case Example 2: Collaborative Partnership for Population Health and Health Equity

Background and Context

Collaborative partnerships are a prominent strategy for intersectoral action for population health and health equity.[6] Established in 2009, the Latino Health for All (LHFA) Coalition is a multisector partnership made up of over 40 community partners. It is supported by a scientific and technical assistance partner, the University of Kansas' Work Group for Community Health and Development. The LHFA Coalition's vision is to "assure health for all"; its mission is to "reduce diabetes and cardiovascular disease among Latinos in Kansas City/Wyandotte County (Kansas) through a collaborative partnership to promote healthy nutrition, physical activity, and access to health services." This ongoing effort has been supported by grants from the National Institute on Minority Health and Health Disparities, the CDC, and community foundations.

Core Elements of the Health for All Model

To address health disparities, the LHFA Coalition implemented the Health for All Model.[47] As depicted in Figure 25-2, this model is also grounded in a community development approach and the Institute of Medicine's Framework for Collaborative Public Health Action.[5,10] The Health for All Model uses five key elements to support community mobilization and community-based participatory research[47] (CBPR). These elements include:

1. **Establishing an organizational structure**. This involves creating organizational arrangements, such as action committees, that promote community participation, decision-making, and targeted action.[48,49] The LHFA Coalition established a Community Advisory Board to provide guidance about the general direction of the coalition, and to make decisions about allocation of funds. The Coalition had three Action Committees, one for each of its goal areas: Healthy nutrition, Physical activity, and Access to health services. The goals were chosen by community representatives based on existing community health assessments and the experience of residents and organizational representatives. Coalition membership has been represented by a broad cross section of people (e.g., members of the local Latino community; agency staff) and community sectors (e.g., government, health organizations, community and cultural organizations).
2. **Action planning to identify community-determined strategies**. Beginning in 2009 (and periodically thereafter), the membership of the LHFA Coalition developed (and updated) a comprehensive community action plan. Specified for each action committee/goal area, this consisted of a listing of prioritized community/systems changes (programs, policies, and practices) that would be implemented by community partners to enhance health behaviors and reduce health disparities. Examples from among the dozens of priority strategies included:
   a) establishing community gardens (nutrition),
   b) creating more spaces for physical activity/soccer (physical activity), and
   c) increasing the availability of health services for which high-quality translation services were available (access to health services).

The action plan provided multiple niches of opportunity for community engagement; it pinpointed where community members and organizational partners could add their contribution to the shared mission.

3. **Community mobilization to stimulate involvement and action**. Community mobilizers have been employed continuously throughout the LHFA Coalition's operation. The community mobilizers' core tasks included:
   a) creating and maintaining opportunities for engagement of LHFA Coalition members and partners;
   b) supporting partners—including Latinos and Latino-serving organizations—in taking action on community-determined strategies;
   c) serving as the public face and point person for the LHFA Coalition; and
   d) assuring technical support for implementation of the community action plan by LHFA Coalition members and partners.
4. **Distribution of resources to support implementation of the action plan**. To support implementation of the action plan, "mini-grants" were distributed to community partner organizations. The community-determined strategies in the action plan were used by the Action Committees to generate ideas for projects and to identify prospective implementers. LHFA members and other community organizations created proposals (e.g., for community gardens, soccer field). Once reviewed and approved by the Action Committee, applications were forwarded to the Community Advisory Board (CAB). All decisions as to whether to fund, and at what

amount, were made by the CAB. The CAB was composed of cochairs of each action committee and two at-large members; scientific partners did not have a vote. Mini-grants (typically $10,000 or less each) were distributed by the CAB during the Coalition's initial five years in operation, and thereafter when resources were available.

5. **Documentation and feedback on progress to promote understanding and improvement**. As discussed in the third case example (below), participatory research methods were used throughout all phases of the project. Scientific partners and community mobilizers, with input from LHFA Coalition members, were responsible for recording the discrete activities and community/system changes brought about by the Coalition to promote physical activity, healthy nutrition, and access to health services. The resulting information—for instance, graphs of the amount and kind of community/system changes—was shared regularly with the LHFA Coalition to occasion reflection on what we are seeing, what it means, and implications for adjustment.[46,50] Reports were produced containing information about LHFA Coalition performance and resulting adjustments made by the Coalition.

Case Example 3: Community-Based Participatory Research (CBPR)

Background and Context

Community-based participatory research (CPBR) is a "collaborative approach to research that equitably involves

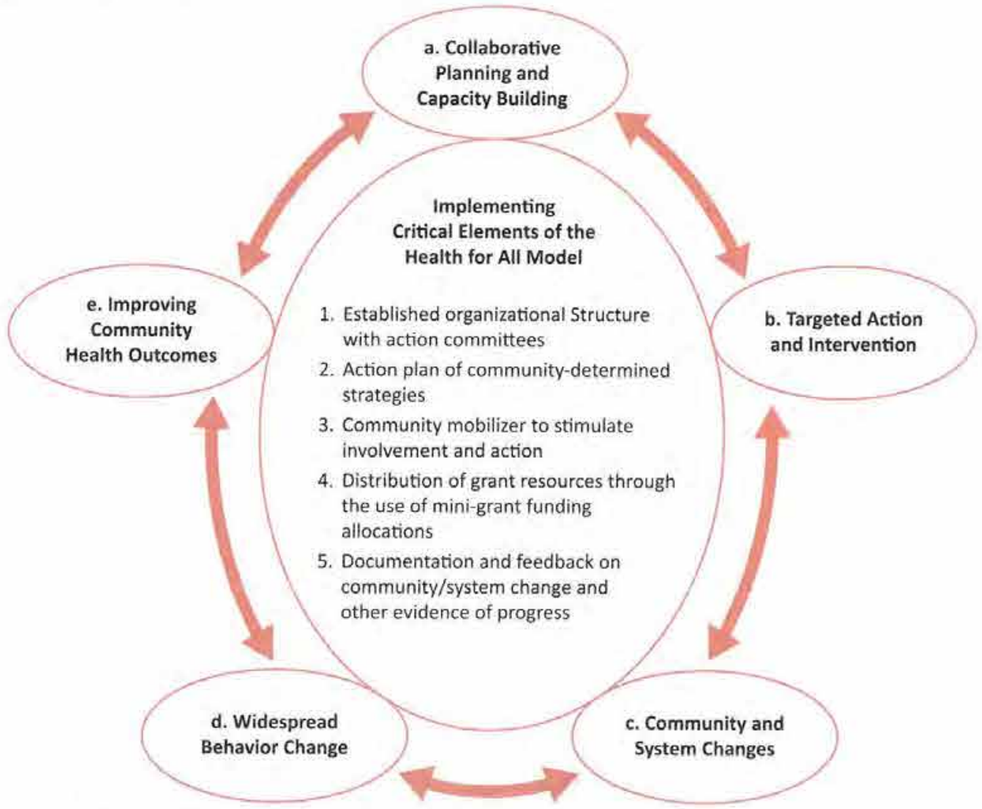

FIGURE 25-2 Five Elements of the Health for All Model Used by the Latino Health for All Coalition

all partners in the research process and recognizes the unique strengths that each brings."[51] Viswanathan and colleagues[52] indicated that essential elements of CBPR include opportunities for colearning by all research partners, a shared role in decision-making, and shared ownership over research processes and products. Researchers have noted that CBPR is a paradigm particularly well-suited to address community development approaches to improve population health and health equity since it helps bridge historical issues, such as distrust, and enhances support for interventions that were codeveloped.[53] CBPR was a key approach used by the Latino Health for All (LFHA) Coalition and its scientific partner (University of Kansas); they worked together in the context of this case example.[26,47]

Principles of Community-Based Participatory Research (CBPR)

Schulz and colleagues[54] articulated a set of principles for CBPR that reflect core aspects of a community development approach. This section outlines how each of the nine CBPR principles was implemented by scientific and community partners as part of the LHFA Coalition's efforts.

1. **CBPR recognizes community as a unit of identity**. Through dialogue, scientific and community partners worked to better understand how Latino community members experienced conditions that put them at risk for health disparities related to chronic diseases, including diabetes and cardiovascular disease. The community was defined as Latino residents residing in a particular low-income area in Kansas City, Kansas. Through years of engagement with community members and partners, scientific partners learned more about how community members perceived and defined their community as shared place, interests, and experiences.
2. **CBPR builds on strengths and resources within the community**. Scientific partners and community members sought to assure engagement of the community in all phases of the community development process, including assessment and collaborative planning, implementation of community-determined strategies, reviewing data and making sense of the findings, and making adjustments. This action cycle was designed to maximize community engagement and utilization of local assets and resources. For example, efforts to assure access to health services benefitted from engagement of existing, highly valued and trusted community health care organizations. Similarly, as part of the nutrition action committee, a community member with an interest in gardening was identified as a champion, and she ultimately provided leadership for seeing the number of community and residential gardens in the area triple in a three-year period.
3. **CBPR facilitates collaborative, equitable partnership in all phases of research**. The membership of the LHFA Coalition, as well as scientific partners, have been engaged in all phases of participatory research. The Coalition-determined community action plan guided the work of the LHFA Coalition, and the Community Advisory Board made decisions about funding for implementing community-determined strategies. Periodically, members review patterns in the data and reflect on what it means—for instance, what factors (e.g., adding a new community mobilizer) may have led to increases/decreases in activities—and implications for adjustment.
4. **CBPR promotes colearning and capacity building among all partners**. Scientific and community partners contribute in ways that are consistent with their respective strengths. For instance, during the initial development and periodic revisions of the community action plan, scientific partners contributed their knowledge and experience with identifying evidence-based policies and practices; and community members contributed their understanding of the community and local context. This information has been used to prioritize selected strategies and to better understand needed adaptation. **Capacity building** has occurred through both informal and formal colearning, training, and technical support. The capacity of researchers to understand the complexity of problems has been enhanced by being engaged on the ground and working alongside community members. More formal workshops and technical support were provided to enhance capacity of community members (e.g., to engage in grant-writing or planning for sustainability).
5. **CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners**. Partners balanced the needs of the funded research with the LHFA membership's focus on action to change conditions in the community. Ongoing dialogue among community and scientific partners, including at monthly action committee meetings, helped to bridge potential conflicts. For example, a source of

tension during the first several years of the LHFA Coalition's efforts was the need to designate a clear and somewhat small area within the broader Latino community as the intervention area, according to the design of the initial NIH grant. This supported the research partners' needs to assemble evidence of the Health for All Model's effectiveness, but it seemed artificially bounded by community partners who worked in a broader jurisdiction. As the LHFA Coalition shifted away from being funded solely by the initial grant from the National Institute of Minority Health and Health Disparities, the "target area" expanded to be more inclusive of all areas of Wyandotte County experiencing health disparities, in keeping with the expectations of community partners.

6. **CBPR emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease.** The LHFA Coalition has sought to live up to this principle through collaborative action at multiple ecological levels—including individuals, families/relationships, organizations, and the whole community. The Coalition's community action plan consisted of strategies identified and selected by community members; from local programs (e.g., Zumba classes in the neighborhood) to environmental changes (e.g., establishing new parks and soccer fields in underserved areas). It assured that activities had local relevance through community-determined strategies and mini-grant funding decisions controlled by the Community Advisory Board.
7. **CBPR involves systems development through a cyclical and iterative process.** The LHFA Coalition has been implementing a model, the Health for All Model (described in Case example #2) that is intended to be both interactive and iterative. The phases on the outer section of the model (see Figure 25-2) are intended to assure a cyclical process; for instance, if changes in behavior and outcomes fall short (e.g., as detected in neighborhood-level behavioral surveys), renewed collaborative planning will lead to refined plans for targeted action for changing conditions.
8. **CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process.** Throughout implementation of the project, the LHFA Coalition has collected different types of data to evaluate its effectiveness. This information is disseminated using multiple means to reach diverse audiences. In periodic sense-making facilitated by scientific partners, community partners use up-to-date information about progress to review what they are seeing, what it means, and implications for adjustment. To promote the activities of the LHFA Coalition, dissemination activities are conducted with local media, and LHFA Coalition members are often part of the communication. Lastly, communications on lessons learned and emerging evidence of effectiveness are delivered to academic and practitioner audiences.
9. **CBPR involves a long-term process and commitment.** The University of Kansas and LHFA Coalition have been working together since 2009, and they have collaboratively generated resources to fully sustain collaborative action through at least 2017. The scientific and community partners share the commitment and responsibility for assuring long-term engagement in the effort to promote healthy behaviors and eliminate health disparities.

Further descriptions of the LHFA Coalition and evidence of effectiveness can be found elsewhere.[26,47]

Sustainability

Sustainability of community development efforts represented in these several case examples have relied on multiple tactics. As described in the Community Tool Box (accessed at http://ctb.ku.edu by searching for "Sustaining the Work or Initiative"), these tactics for sustainability, and examples from these cases, include:

- Sharing positions and resources (e.g., Latino Health for All Collaborative partnership—community mobilizer sharing office space within El Centro, a key partner organization);
- Becoming a line item in an existing budget of another organization (e.g., LDCHD Community Health Planning and Improvement—the health department provides funding for a dedicated position);
- Incorporating the initiative's activities or services into another organization with a similar mission (e.g., LDCHD Community Health Planning and Improvement—the United Way requests that its programs report on contributions to the community health improvement plan);
- Applying for grants (e.g., Latino Health for All Collaborative partnership—continuously funded by a series of related grants);
- Tapping into available personnel resources (e.g., LDCHD Community Health Planning and Improvement and the Latino Health for All Coalition—taken together, they have scores of partner organizations that permit staff time to make a contribution).

BUILDING CAPACITY OF THE HEALTHY COMMUNITIES WORKFORCE

Building healthy communities involves people working together to address health and development concerns that matter to them.[10] The **community development workforce** is necessarily broad and distributed; successful community development efforts extend far beyond the health sector. Sectors essential to community health development include: employers and businesses; academia; the media; governmental public health agencies; the health care delivery system; nonprofit, nongovernmental, voluntary, and social entities, including ethnic and cultural groups; advocacy organizations; and the faith community.[5] Meaningfully engaging various sectors of the community—including people most affected by health disparities—requires a diverse workforce skilled in community development methods.

Community development workers can serve in the role of guide, enabler, or expert.[4] Guides help "the community establish, and find means of achieving, its own goals . . . the choice of direction and method of movement must be that of the community."[4] The enabler helps facilitate the community organization process by focusing discontent, encouraging organization, developing good interpersonal relations, and emphasizing common objectives.[4] The role of the expert is to provide technical assistance, data and evaluation support, and advice on methods. There are outside encouragers or developers—such as university partners or those providing technical support—and indigenous ones—local leaders who support and emerge from the process of community development.[55] The best measure of whether the development effort has been successful is whether it becomes self-perpetuating, as when new generations of developers emerge as the work continues over time.[55]

Core Competencies for the Community Health and Development Workforce

Community development approaches and related skills are critical to assuring conditions for health and well-being for all. Public health essential services—and related standards for a functional local health department—include: monitoring health status through community assessments; supporting community-engaged planning to identify health issues; and mobilizing community partnerships to solve identified problems.[18]

Related core competencies for the community health development workforce can be articulated within the *Healthy People 2020's MAP-IT FRAMEWORK*: *Mobilize* community partners; *Assess* community needs; *Plan* to address these needs; *Implement* the improvement plan; and *Track* the community's progress. Table 25-3 displays core competencies related to this framework, specific skill areas, and available supports for learning these skills, including those available through the Community Tool Box[56] (CTB) (http://ctb.ku.edu/) and other sources.

Capacity Building to Support Community Health and Development

Like other aspects of public health practice, community development requires a prepared workforce.[57] Building the capacity of individuals and groups in the community to come together to organize and take action is part of the community development process.[50,58] Eade and Williams[59] make the case that "strengthening people's capacity to determine their own values and priorities, and to organize themselves to act on these, is the basis of development" (p. 5). Since people, context, and conditions are always changing in communities, capacity building is seen as an ongoing aspect of the community development process.[60] This requires clarity about whose capacities need to be enhanced, what capacities need to be developed, and why or for what purpose.[60] Typically, capacity building needs to occur at multiple levels, including at the organizational and community levels to support change and improvement in both communities and the systems that are supposed to serve them. It is also important to identify what skill or competency areas need to be strengthened among community members and development partners—for instance, in community assessment, planning, intervention, advocacy, leadership development, evaluation, and sustainability.

Often, capacity-building activities include training, technical assistance, and other supports. These are typically offered through intermediaries such as technical assistance providers, universities, government partners, or grantmakers. Workshops, webinars, and online courses are common modes of delivery. Web-based supports, such as the free and open source Community Tool Box[56] (http://ctb.ku.edu/), can help assure affordable and just-in-time supports for implementing community development approaches.[61,62] In a capacity-building approach, the locus of responsibility for community development is shared among both technical experts and community members, and both are colearners in the community development process.

TABLE 25-3 Core Competencies for Community Development for Health, Related Skill Areas, and Some Available Supports for Workforce Development

Core Competencies for the Public Health Workforce	Some Specific Skill Areas	Some Supports for Workforce Development—from the Community Tool Box (CTB) and Other Sources
Mobilization	• Establishing a vision and mission • Bringing people together • Representing community stakeholders • Building partnerships • Assuring technical assistance • Enhancing cultural competence	• CTB Toolkit: Increasing Participation and Membership • CTB Toolkit: Creating and Maintaining Coalitions and Partnerships • CTB Toolkit: Enhancing Cultural Competence • CTB Chapter 4: Getting Issues on the Public Agenda • CTB Chapter 7: Encouraging Involvement in Community Work • CTB Chapter 12: Providing Training and Technical Assistance • CTB Chapter 27: Cultural Competence in a Multicultural World
Assessment	• Determining community needs • Identifying community assets and resources	• CTB Toolkit: Assessing Community Needs and Resources • CTB Toolkit: Analyzing Problems and Goals • CTB Chapter 3: Assessing Community Needs and Resources • Healthy People 2020 Tool: Brainstorm Community Assets • Healthy People 2020 Tool: Exercise: Prioritizing Issues • CDC CHANGE Action Guide
Planning	• Developing strategic and action plans • Developing objectives • Developing logic models	• CTB Toolkit: Developing Strategic and Action Plans • CTB Toolkit: Developing a Framework or Model of Change • CTB Chapter 8: Developing a Strategic Plan • Healthy People 2020 Tool: Defining Terms • Healthy People 2020 Tool: Setting Targets for Objectives • CDC Evaluation Guide: Developing and Using a Logic Model • CDC Change Community Health Improvement Planning Template
Intervention/ Implementation	• Developing effective interventions that fit local context • Influencing policy development • Developing a plan for communication • Planning for sustainability	• CTB Toolkit: Developing an Intervention • CTB Toolkit: Influencing Policy Development • CTB Toolkit: Sustaining the Work or Initiative • CTB Chapter 6: Promoting Interest in Community Issues • Healthy People 2020 Coalition Self-Assessment
Tracking	• Developing evaluation plans • Documenting progress • Using feedback to improve the effort • Celebrating and communicating progress	• Toolkit: Evaluating the Initiative • CTB Chapter 36: Introduction to Evaluation • CTB Chapter 37: Operations in Evaluating Community Interventions • CTB Chapter 38: Some Methods for Evaluating Comprehensive Community Initiatives • Healthy People 2020: Measuring Progress • CDC Evaluation Guide: Developing an Evaluation Plan

SUMMARY

Community development is integral to the work of assuring conditions for health and well-being for all of us. Its core attributes—community participation, intersectoral action, and locally determined goals—are thoroughly consistent with the theory and practice of public health. With its emphasis on changing communities and systems, it embodies the process and intermediate outcome of collaborative public health action. Selected case examples—from community health planning, collaborative partnerships, and community-based participatory research—illustrate the processes of community development for population health improvement. As the evidence base for implementing community development practices is extended, this approach will be even more vital to efforts to improve population health and health equity. To go to scale, we need to enhance core competencies for community development in a broad and diverse workforce of community members and professionals from different disciplines and sectors. Working collaboratively in the spirit of social justice, we can enable communities—locally and globally—to assure conditions for the health and well-being of all our members.

REVIEW QUESTIONS

1. What is community development?
2. What are community development approaches for health and health equity?
3. Describe three major models of community organization practice.
4. Describe the Institute of Medicine's (IOM) Framework for collaborative public health action and the 12 processes often associated with promoting community health and development.
5. Describe the sectors of the community essential to successful community development for health.
6. Describe the five-phase *Healthy People 2020 MAP-IT Framework* guiding implementation efforts related to achieving health objectives for the nation.
7. Describe the core practices for community health planning and improvement (according to the CDC report on core practice areas).

REFERENCES

1. Murphy FG, Fawcett SB, Schultz JA, Holt C. Fundamental core concepts in the community engagement, organization, and development process. In: Murphy FG, ed. *Community Engagement, Organization, and Development for Public Health Practice*. New York: Springer; 2013: 1–30.
2. World Health Organization. The Ottawa charter for health promotion. http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html. Published 1986. Accessed October, 2014.
3. Christenson JA, Robinson JW. *Community Development in Perspective*. Ames, IA: Iowa State University Press; 1989.
4. Ross M. *Community Organization: Theory, Principles, and Practice*. New York: Harper & Row, Publishers; 1967.
5. Institute of Medicine. (2003). The community. In: *The Future of the Public's Health in the 21st Century*. Washington, DC: National Academy Press; 2003: 178–211. http://books.nap.edu/openbook.php?record_id=10548&page=178. Accessed October 2014.
6. Fawcett S, Schultz J, Watson-Thompson J, Fox M, Bremby R. Building multisectoral partnerships for population health and health equity. *Prev Chronic Dis*. 2010; 7(6). http://www.cdc.gov/pcd/issues/2010/nov/10_0079.htm. Accessed October 2014.
7. Bracht N, ed. *Health promotion at the community level*. Newbury Park, CA: Sage Publications, Inc; 1990.
8. Green L, Kreuter M. *Health Promotion Planning: An Educational and Ecological Approach*. 4th ed. Boston: McGraw-Hill; 2005.
9. Green I, Raeburn I. Contemporary development in health promotion—Definition and challenges. In: Bracht N, ed. *Health Promotion at Community Level*. Newbury Park, CA: SAGE Publishing; 1990.
10. Fawcett SB, Francisco VT, Hyra D, Paine-Andrews A, Schultz JA, Roussos S, Fisher JL, Evensen P. Building healthy communities. In: Tarlov A, St. Peters RF, eds. *The Society and Population Health Reader: A State and Community Perspective*. Itasca, IL: F.E. Peacock Publishers; 2000: 314–334.
11. Braveman P. Health disparities and health equity: Concepts and measurement. *Annu Rev Public Health*. 2006; 27: 167–94. doi: 10.1146/annurev.publhealth.27.021405.102103
12. Braveman P, Gruskin S. (2003). Defining equity in health. *J Epidemiol Community Health*. 2003; 57(4): 254–248.
13. Baum FE. *The New Public Health*. 3rd ed. South Melbourne, VIC: Oxford University Press; 2008.
14. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization; 2008.
15. Jackson S, Birn AE, Fawcett SB, Poland B, Schultz JA. Synergy for health equity: Integrating health promotion and social determinants of health to address health inequity in the Americas. *Rev Panam Salud Publica*. 2013; 34(6): 473–480.

16. Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2. In: *Policy and Practice*. Geneva, Switzerland: WHO Press; 2010. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf. Published 2010. Accessed 2014.
17. Cox FM, Erlich JL, Rothman J, Tropman JE, eds. *Strategies of Community Organization*. Itasca, IL: F.E. Peacock Press; 1979.
18. Tsouros, A. The WHO Healthy Cities Project: State of the art and future plans. *Health Promot Int*. 1995; 10(2): 133–141.
19. National Association of County and City Health Officials. Operational definition of a functional local health department. http://www.naccho.org/topics/infrastructure/accreditation/upload/OperationalDefinitionBrochure-2.pdf. Published November 2005. Accessed October 2014.
20. Healthy People 2020. Program planning. http://healthypeople.gov/2020/Implement/MapIt.aspx. Updated November 18, 2014. Accessed November 18, 2014.
21. Fawcett SB, Francisco VT, Paine-Andrews A, Schultz JA. Working together for healthier communities: A research-based memorandum of collaboration. *Public Health Rep*. 2000; 115(2): 174–179.
22. Green L. From research to "best practices" in other settings and populations. *Am J Health Behav*. 2001; 25(3): 165–178.
23. Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annu Rev Public Health*. 2000; 21: 369–402.
24. Community Preventative Services Taskforce. The guide to community preventative services: The community guide—What works to promote health. http://www.thecommunityguide.org. Published 2013. Updated November 12, 2014. Accessed November 12, 2014.
25. Yin R. *Case Study Research: Design and Methods*. 4th ed. Los Angeles, CA: SAGE Publications; 2009.
26. Watson-Thompson J, Fawcett SB, Schultz JA. Differential effects of strategic planning on community change in two urban neighborhood coalitions. *Am J Commun Psychol*. 2008; 42: 25–38. doi: 10.1007/s10464-008-9188-6.
27. Collie-Akers VL, Fawcett SB, Schultz JA. Measuring progress of collaborative action in a community health effort. *Rev Panam Salud Publica*. 2013; 34(6): 422–428.
28. Guerra N, Backer TE. *Casebook on Youth Violence Prevention Projects—Four Key Elements for Success*. Encino, CA: Human Interaction Research Institute; 2003. http://www.csun.edu/sites/default/files/finalrep130.pdf.
29. Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC. Tools for implementing an evidence-based approach in public health practice. *Prev Chronic Dis*. 2012. doi: 9:110324. http://dx.doi.org/10.5888/pcd9.110324.
30. Keene Woods N, Watson-Thompson J, Schober DJ, Markt B, Fawcett S. Functioning and sustainability: An empirical case study of the effects of training and technical assistance on community coalition. *Health Promot Pract*. 2014; 15(5): 739–749. doi: 10.1177/1524839914525174.
31. Watson-Thompson J, Fawcett SB, Schultz JA. A framework for community mobilization to promote healthy youth development. *Am J Prev Med*. 2008; 34: S72–S81. http://www.ajpmonline.org/article/PIIS0749379707007581/fulltext.
32. Zakocs RC, Edwards EM. What explains community coalition effectiveness? A review of the literature. *Am J Prev Med*. 2006; 30(4): 351–61.
33. Schultz J, Collie-Akers V, Fernandez C, Fawcett S, Ronan M. Implementing community-based participatory research with two ethnic minority communities in Kansas City, Missouri. *International Journal of Migration, Health and Social Care*. 2009; 5(1): 47–57.
34. Watson-Thompson J, Keene Woods N, Schober DJ, Schultz JA. Enhancing the capacity of substance abuse prevention coalitions through training and technical assistance. *J Prev Interv Community*. 2013; 41(3): 176–187.
35. Hargreaves MB. Using complexity science to improve the effectiveness of public health coalitions. In: Minai A, Braha D, Bar-Yam Y, eds. Online proceedings of the Seventh International Conference on Complex Systems. http://www.necsi.edu/events/iccs7/papers/e839e1bbe9ea54c690072c99a4b1.pdf. Published 2007. Retrieved 2014.
36. Kreuter MW, Lezin NA, Young LA. Evaluating community based collaborative mechanisms: implications for practitioners. *Health Promot Pract*. 2000; 1(1): 49–63.
37. Merzel C, D'Affitti J. Reconsidering community-based health promotion: Promise, performance, and potential. *Public Health Matters*. 2003; 93(4): 557–574.
38. Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press; 1988.

39. Institute of Medicine. *Improving health in the community: A role for performance monitoring*. Washington, DC: National Academy Press; 1997.
40. Turnock BJ. *Public Health: What It Is and How It Works*. 4th ed. Sudbury, MA: Jones & Bartlett Publishers; 2009.
41. National Association of County and City Health Officials. MAPP Framework. Mobilizing for action through planning and partnerships: Web-based framework tool. http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm. Published 2001. Accessed 2014.
42. Catholic Health Association. Step 2: Determine the purpose and scope of the community health needs assessment. Assessing and addressing community health needs. http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4. Published 2011. Updated June, 2013. Accessed November 2014.
43. Association for Community Health Improvement. Step 2: Determine the purpose and scope of the community health needs assessment. Community Health Assessment Toolkit. www.assesstoolkit.com. Published 2002. Accessed November 2014.
44. Fawcett S, Holt C, Schultz J. Some Recommended Practices for Enhancing Community Health Improvement. University of Kansas Work Group for Community Health and Development Report to the CDC Office of Prevention through Healthcare. http://ctb.ku.edu/sites/default/files/site_files/recommended_practices_for_enhancing_community_health_improvement.pdf. Published 2011. Accessed 2014.
45. Lawrence Douglas County Health Department. Community Health Plan. Lawrence Douglas County Health Department website. http://ldchealth.org/information/about-the-community/community-health-improvement-plan. Published 2013. Accessed 2014.
46. Cutts T, Rafalski T, Grant C, Marinescu R. Utilization of Hot Spotting to Identify Community Needs and Coordinate Care for High-Cost Patients in Memphis, TN. *Int J Geogr Inf Syst*. 2014; 6(1): 23–29. doi: 10.4236/jgis.2014.61003.
47. Fawcett SB, Schultz JA. Using the Community Tool Box's Online Documentation System to Support Participatory Evaluation of Community Health Initiatives. In: Minkler M, Wallerstein N, eds. *Community Based Participatory Research for Health: From Process to Outcomes*. 2nd ed. New York: Jossey-Bass; 2008.
48. Fawcett SB, Collie-Akers V, Schultz JA, Cupertino P. Community-based participatory research within the Latino health for all coalition. *J Prev Interv Community*. 2013; 41(3): 142–154. doi: 10.1080/10852352.2013.788341
49. Mattessich P, Monsey B. *Collaboration: What Makes it Work: A Review of Factors Influencing Successful Community Building*. Saint Paul, MN: Amherst H. Wilder Foundation; 1992.
50. Ploeg J, Dobbins M, Hayward S, Ciliska D, Thomas H, Underwood J. Effectiveness of community development projects. http://web.cche.net/ohcen/groups/hthu/95–5abs.htm. Published 1996. Accessed October, 2014.
51. Fawcett SB, Boothroyd R, Schultz JA, Francisco VT, Carson V, Bremby R. Building capacity for participatory evaluation within community initiatives. In: Suarez-Balcazar Y, Harper G, eds. *Empowerment and Participatory Evaluation of Community Interventions: Multiple Benefits*. New York: Haworth Press, Inc; 2003.
52. W. K. Kellogg Foundation. Definition of CBPR adopted at the spring networking meeting of the Community Health Scholars Program. Ann Arbor, MI; 2001. http://depts.washington.edu/ccph/commbas.html.
53. Viswanathan M, Ammerman A, Eng E, et al. Community-based participatory research: Assessing the evidence: Summary. In: AHRQ Evidence Report Summaries. Rockville, MD: Agency for Healthcare Research and Quality (US); 2004. http://www.ncbi.nlm.nih.gov/books/NBK11852.
54. Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *Am J Public Health*. 2010; 100(S1): S40–46.
55. Schulz AJ, Israel BA, Selig SM, Bayer IS. Development and implementation of principles for community-based research in public health. In: MacNair RH, ed. *Research Strategies for Community Practice*. Binghamton, NY: Haworth Press, Inc; 1998: 83–110.
56. Biddle WW, Biddle LJ. *The Community Development Process*. New York: Holt, Rinehart & Winston; 1965.
57. University of Kansas Work Group for Community Health and Development. Community Tool Box. Community Tool Box website. http://ctb.ku.edu. Updated 2014. Accessed November, 2014.
58. World Health Organization. The World Health Report 2006: Working together for health. http://www.who.int/whr/2006/en/. Published 2006. Accessed 2014.

CHAPTER 26

Public Health Preparedness

Linda Young Landesman, DrPH, MSW • Isaac B. Weisfuse, MD, MPH

LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1. Describe types of disasters.
2. Identify the types of public health problems caused by disasters.
3. Understand the key components of health systems preparedness.
4. Describe and explain the role of local health departments in preparing and responding to emergencies.

KEY TERMS

disasters
emergency management
first responder
incident command system (ICS)
preparedness
response
National Incident Management System (NIMS)