PART FOUR  PROVISION OF PUBLIC HEALTH SERVICES


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CHAPTER 25
Community Development for Population Health and Health Equity

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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

INTRODUCTION

Communities throughout the world—and the people and settings that comprise them—are a primary resource and focus for public health action. In this multi-level 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, identity, and 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 interests 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 of 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 achieve the economic, social, and cultural conditions of communities.”2 The U.N. also stated that a key role of intergovernmental organizations is to link people of the community with outside resources to achieve locally determined goals.3 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.4 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 Health promotion refers to the “process of enabling people to increase control over and to improve their health.”8 An ecological model of health promotion sees population health as an interaction among behavior and environmental factors at multiple ecological levels.9 As a process of community development, health promotion is ongoing and unfolding over time, not a one-time response to a crisis or outbreak. The produce of health promotion is a continuum of outcomes and changes, 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 capacity building),
d) widespread behavior change; and

e) improvement in population-level outcomes (e.g., incidence and prevalence of childhood obesity or violence).10,11

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.12 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 in influencing those conditions (e.g., through political rights, fully functioning civil society).13,12

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 of health includes the following 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) intermediate determinants (e.g., material circumstances, behaviors, and biological factors; psychosocial factors; health care system).

(See Chapter 5 for more detail on social determinants of health.)

Community development approaches for health and health equity aim to address and influence environmental and social factors related to the priority issues/goals for, by, and in the community, providing information and services, modifying access and opportunities, and using advocacy to influence other factors. Community development approaches also seek to challenge the mechanisms by which social determinants produce inequities. They aim to reduce:

a) differential exposure to intermediary factors (e.g., through policies that reduce exposure 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.

MODELS OF COMMUNITY DEVELOPMENT FOR HEALTH

This section leads with several prominent models of community development and health promotion from the fields of community health.

Models of Community Organization Practice

Rothenberg and colleagues16 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 well as community leaders. It is most commonly seen in rural communities, but is also used in urban settings. Community leaders are typically well informed of community needs and are able to identify and respond to them. This model is based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. In this model, the community is seen as the primary decision-making body, and the role of the government is to support and facilitate the process. The government also provides technical assistance and funds for the implementation of community-driven projects.

In the social planning model, community members are involved in the planning and implementation of projects, but the government retains ultimate control over the process. This model is often used in urban areas, where the government has a stronger presence and is responsible for providing basic services such as water and sanitation. In this model, the government is seen as the primary decision-making body, and the role of the community is to provide input into the decision-making process. The government provides technical assistance and funds for the implementation of community-driven projects.

In the social action model, community members are involved in the implementation of projects, but the government does not provide technical assistance or funding. This model is often used in rural areas, where the government is less involved and community members are more likely to be able to implement projects on their own. In this model, the community is seen as the primary decision-making body, and the role of the government is to support and facilitate the process. The government also provides technical assistance and funds for the implementation of community-driven projects.

All three models are based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. The difference between the models lies in the extent to which the government is involved in the decision-making process.

In summary, community organization practice is an important aspect of community development for health and health equity. It is based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. The models of community organization practice vary in terms of the extent to which the government is involved in the decision-making process. The locality development model is based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. The social planning model is based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. The social action model is based on the belief that communities should be able to determine their own needs and priorities and be able to develop and implement solutions to their problems. The models of community organization practice are important because they can help to ensure that communities are able to develop and implement solutions to their problems in a way that is responsive to their unique needs.
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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.2,23

However, the evidence is mixed as to how well community partnerships improve outcomes at either the level of behavioral risk/protection factors or population 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.30-36 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 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 multicomunity 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.3,37-39 There are a number of prominent models of community health improvement; they include the MAPP Framework37 of the National Association of Counties and City Health Officials (NACCHO/CDC), and those of the Catholic Health Association40 and the Association for Community Health Improvement41 (ACH). 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 improvement.42 This work began in 2006 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 over the past 11 years.44 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.

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 its 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 those in 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. For the LDCHD community health improvement effort, small area analysis was
used to better understand how poverty and out-
comes 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 lasting improvement efforts. In the LCDDH community health improvement effort, data were collated 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 LCDDH 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 centers, the United Way, government agencies, the transit system, and other asset owners 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. 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 LCDDH 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 healthy foods, recreation, 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 LCDDH 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 LCDDH has funded new positions to support implementation of the plan.

8. Participatory monitoring and evaluation of GHI efforts. In this approach, stakeholders are involved in identifying indicators of success for each community-determined goal area. This helps to measure progress for accountability— and information for quality improvement—that are accurate, feasible to collect, and sensitive to the context. In the LCDDH 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. 30 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 LCDDH effort, diverse stakeholders have been engaged throughout the process. Collaborative education 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 LCDDH effort, the steering committee meets periodically to review progress on implementation of the plan.

11. Create formal public 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 LCDDH effort, focus groups with community partners were used to assess satisfaction with progress on each prioritized goal area within 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. 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 Institutes of 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. As depicted in Figure 25-2, this model is also grounded in a community development approach and the Institute of Medicine's Framework for Community Health Action. The Health for All Model uses five key elements to support community mobilization and community-based participatory research (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. 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 has three Community Committees, each in each of their goal areas: Healthy nutrition, Physical activity, and Access to health services. The goals were chosen by community representatives based on population assessments and the experience of residents and organizational representatives. Coalition membership has been represented by a broad cross-section of people (e.g., a 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). This was 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 numerous 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 Committees, these were forwarded to the Community Advisory Board (CAB). All decisions as to whether to fund, and at what
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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. 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 (CBPR) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings.1,25 Viewswanith and colleagues26 indicated that essential elements of CBPR include opportunities for co-creating 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 codveloped.26 CBPR was a key approach used by the Latino Health for All (LHFA) Coalition and its scientific partner (University of Kansas); they worked together in the context of this case example.6,27

Principles of Community-Based Participatory Research (CBPR)

Schulz and colleagues28 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 partners 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 benefited 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 co-learning 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 programs, 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 co-learning, 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 sound goal area that was beneficial to all members of the broader Latino community as the intervention area, according to the design of the initial NIH grant. This supported the research partners’ needs to assessed the need for the Health for All Model’s effectiveness, but it seemingly very broad and distributed: 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 are recognized and attended 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—both individual, families, relationships, organizations, and the whole community. The Coalition’s community action plan consists 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 in an underserved community area). It was assured that activities had local relevance through community-relevant 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 7-1) are to ensure a cyclical process for: (a) assessing changes in behavior and outcomes that fall short (e.g., as detected in neighborhood-level behavioral survey), 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. Through 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 program 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, communication on lessons learned and emerging evidence of effectiveness are delivered to academic and practitioner audiences.

9. CBPR involves a long-term and commitment. The University of Kansas and LHFA Coalition have been working together since 2009, and they have collaboratively generated resources to fulfill all collaborative action through at least 2017. The scientific and community partners share the commitment and responsibilities for ensuring engagement in this effort to promote healthy behaviors and eliminate health disparities.

Further descriptions of the LHFA Coalition and evidence of effectiveness can be found elsewhere.20,21

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://cbh.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 leadership);
- Becoming a fine item in an existing budget of another organization (e.g., LDCHC 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; advocates, organizations, and the faith community. Meaningfully engaging various sectors of the community—including people most affected by health disparities—requires a diverse workforce skilled in community development methods.

Building community development workers can serve in the planning of guiding long-term activities.22 Guides help the community establish, and find means of achieving, its own goals . . . the vision of choice and method of movement must be that of the community.23 The enabler helps to facilitate the community organization process by focusing on a specific segment, organizing an enabling role, developing good interpersonal relationships, and emphasizing community objectives.24 The role of the expert is to provide technical assistance. It is also possible to provide technical assistance and advisory, 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 local-level delivery Web-based supports, such as the free and open source Community Tool Box (http://cbh.ku.edu/), can help assure affordable and just-in-time supports for implementing community development approaches. Another approach, the locus of responsibility for capacity development is shared among both technical experts and community members, and both are collocated 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

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<td>Planning for sustainability</td>
<td>Healthy People 2020 Tool: Defining Terms</td>
</tr>
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<td>Tracking</td>
<td>Developing evaluation plans</td>
<td>Healthy People 2020 Tool: Setting Targets for Objectives</td>
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<td>Documenting progress</td>
<td>CDC Evaluation Guide: Developing and Using a Logic Model</td>
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<td>Using feedback to improve the effort</td>
<td>CDC Change Community Health Improvement Planning Template</td>
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SUMMARY

Community development is integral to the work of assessing conditions for health and well-being for all of us. Its core attributes—community participation, intersectional 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.

CHAPTER 25 COMMUNITY DEVELOPMENT FOR POPULATION HEALTH AND HEALTH EQUITY

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

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)