COMMUNITY ENGAGEMENT, ORGANIZATION, AND DEVELOPMENT FOR PUBLIC HEALTH PRACTICE
Community Engagement, Organization, and Development for Public Health Practice
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Community Engagement, Organization, and Development for Public Health Practice

Frederick G. Murphy, MSHyg, MPIA

Editor
This textbook is dedicated to the many community leaders and public health practitioners living and working in diverse communities here in the United States and throughout the Globe. We say thank you to these servant leaders who have committed their life work to improving the quality of life for disparate and disenfranchised populations residing in communities and villages worldwide.

This work is also dedicated to all strata of quality leadership and stewardship, especially those unsung heroes, such as Terrell M. Bond, MD, MPH; Julia Smith and Ms. Strickland (Joyland Community City of Atlanta NPU Y); Louis Sullivan, MD, Former Secretary of Health and Human Services and Former President and Founder of Morehouse School of Medicine; Ruth Goode-White, Former Director of Sickle Cell Disease Center of Pittsburgh; Tom and Zora Murphy of Pittsburgh, Pennsylvania, and many others.
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Foreword

In the 21st century, it is well documented by the academic health science community and health care providers that only a small percentage of health can be directly attributed to health care. While that is true, those who are disproportionately experiencing excess disease, disability, dysfunction, and premature deaths desperately need health services that are more available, accessible, and acceptable. Also, the inequitable distribution of social, economic, and environmental resources demands new and renewed means of building strong community-based partnerships to address social determinants of health and health care inequities. However, successfully integrating what we know about effective health care delivery, the distinctive cultures of our communities, and what we know about public health theory and practice is an enormous task.

Throughout my career, I have been heavily involved in various sectors of public and community health ranging from providing direct patient care, overseeing the activities of an urban public health department, to directing one of the nation’s largest federally qualified community health centers. It is from this perspective that I am convinced that unless the health professions community fully invests and assists in community empowerment, poor individual and population health status outcomes, excess spending, and overuse of health technology will continue. We can do better if we listen to the voices of our communities!

Community Engagement, Organization, and Development for Public Health Practice, edited by Frederick G. Murphy, MSHyg, MPIA, confronts the abovementioned challenges in novel and provocative ways. It emphasizes important nontraditional approaches and partnerships, and the need to readjust methods based on the 21st-century community changes. It calls for the reassessment of existing community partnerships, and the establishment of new partnerships to readily address pressing community needs, and for creation of new community-based translation strategies to address high-risk behaviors and events. Issues of community organization and development, boundaries, ethics, servanthood, cultural competency, partnership, faith, environmental health, equity and resilience, and evaluation are saliently and thought-provokingly discussed.
Murphy and the list of scholars solicited to write the contributing chapters in this book have captured the complex issues of community engagement, organization, and development that have mystified public health practice. While the challenges addressed in the chapters of this textbook have been previously identified, and proposed solutions have been previously published, there have been few texts that have gathered these issues and solutions under one umbrella. Not only has Murphy brought together a transdisciplinary group of public health theoreticians and practitioners, interestingly, he has also coauthored several of the chapters, which provides a uniquely consistent voice throughout the book.

This textbook provides valuable information, examples of strategies, and real-life community experiences and “lessons learned” that should be shared with all segments and sectors in the country. It identifies skills required to both analyze the health and health care delivery challenges of minority and underserved communities and to understand the social, cultural, environmental, and economic determinants of health and disease. Most importantly, this textbook provides a renewed translation of the “community engagement, organization and development process.” It also speaks to the creation of partnership through “formal” coalition building, empowering grassroots communities to address social determinants of health, recognizing that no one group, be it health care providers, public health practitioners, or community members, can accomplish the many tasks required for changing social, economic, and environmental conditions that impact health.

Moreover, this book is a vital resource to a new generation of community health practitioners, educators and organizers working in “grassroots communities” as they try to stay relevant to, and in fact ahead of, the inevitable social, environmental, and public health changes taking place. It is also important to note that the skills and approaches discussed herein are critical elements of a bridge between local neighborhoods and the medical school that enables the creation of innovative programs of education, research, and service focused on the special health problems of minority and other underserved populations globally, including those in the developing world. Undergraduate and graduated students; junior and senior faculty in the liberal arts and physical and biological sciences, business and information science, engineering and technology and professional schools will benefit from the outstanding scholarly work contained in this book. Moreover, those who are actively engaged in the public and private sectors that provide goods and services to the general public, as well as targeted population groups, will also benefit from the information provided. I look forward to learning about how this book is used and the responses based on the experiences of its users.

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Community Engagement, Organization, and Development for Public Health Practice is first and foremost a textbook for 21st-century public health advocates who are coming of age in a global environment fraught with historic and ongoing tensions between privileged and less-privileged communities. Through this book, students who were born after the pioneering era in community organization and development will sit at the foot of the pioneers and learn, through reading their stories, the best practices those groundbreakers learned through hard-fought battles. The authors write from their long history of community development, in which principles have been forged, tested, and refined.

Through educating public health advocates of the future, these pioneers aspire to develop the leadership required to build effective networks of community leaders within the communities they serve. This book addresses the key competencies of an effective community leader in the 21st century: personally empowered, lifelong learner and educator, facilitator of the empowerment process who inspires others to achieve their highest potential, knowledgeable in ways to build effective community coalitions, steward of personal and environmental resources, a savvy and capable political strategist, and keenly aware of the interdependent nature of local, national, and global issues (Robinson & Green, 2011).

A practical, theory-based approach to dealing with community health issues, as-yet unknown, emerges from these chapters. The outstanding authors of this edited work make a strong claim for public health as the lynchpin of achieving social equity in an increasingly inequitable world. This is a departure from other textbooks on community organization and development, which tend to focus primarily on economic development issues (Robinson & Green, 2011). While other books have covered community empowerment and community development—important parts of a grassroots movement’s engine—this book examines how that engine, placed in the right vehicle, can help transport a community from sickness to health.

A community development model is highly complex, beginning with the definition of community, which may be defined by its geographic
boundaries or by common interests of a face-to-face organization or increasingly by a virtual group brought together in cyberspace. “Development” also has various meanings depending on who is defining the need and how to meet the identified need or how to solve the underlying problem that created the need. One could argue that the one who has the power to define development wields a powerful social determinant of health. For example, the need for “urban development” may be defined by some as “cleaning up blighted areas” with a solution that demolishes poor housing and replaces them with parking lots, as was done in Pittsburgh. Others would define the need to be reversing long years of neglect in which there was little to no economic investment or job development, as in those Pittsburgh neighborhoods, despite their community cohesion and desire for local opportunities. The huge, negative health and social impact on community residents in that Pittsburgh community when the first rather than the second need definition was enacted is graphically detailed in Fullilove’s history of urban development (Fullilove, 2004).

There is a growing recognition that this definitional diversity reflects core differences in community development. Geoghegan and Powell (2008) identify three typologies: neoliberal, where civil society serves needs defined by economic developers; corporatist, where the state, market, and civil society partner define and resolve issues; and activist, where empowered communities provide an opposing voice to neoliberalism. The United Nations Environment Program (2007) characterizes four typologies depending on the priority; placed first among priorities for action are markets, policy, security, or sustainability. Scenarios for the 21st century related to which of these typologies is prioritized clearly show that sustainability trumps the others for increasing global health and welfare. The sustainability approach is characterized by a corporatist model, but one that further prioritizes improving the environment and human well-being, with a strong emphasis on equity, transparency, and legitimacy for all partners. And, this is the approach taught by this book.

One of the toughest parts of this approach is building and maintaining effective coalitions and partnerships. Frisch and Servon (2006) describe a community development system, including government entities at all levels; national intermediaries such as the Local Initiatives Support Corporation that provide a formal structure for community development with funding, investments, and other resources such as training and technical assistance, community development financial institutions such as microloan funders, community development corporations such as the Association for Enterprise Opportunity, which are nonprofit organizations that are designed to improve the community’s quality of life through support of local efforts to develop services (like child care, early developmental education, as well as housing, etc.); community-based development organizations that tend to embrace the activist approach (e.g., ACORN); various nonprofit organizations, including faith-based organizations;
private foundations; for-profit organizations; professional associations; and educational institutions such as community colleges and universities. While this list can be daunting to even the most seasoned public health advocate, the real-world case studies in this book illustrate, by both precept and example, how to bring the disparate pieces together for effective public health action.

Changes come about through dedicated and long-term efforts. The 19th-century Progressive Movement bore fruit beginning early in the 20th century and continued for more than 70 years as a potent social determinant of health. We are now seeing the fruits of a backlash movement that began to coalesce in the 1970s and threatens to undo much of the improvement in the public’s health engendered by the Progressive Movement. If actions in the 21st century are to reflect a new and sustainable approach to problem solving, the movement must be well organized and educated. The shared experiences of the authors of this book provides a guidebook that should serve now and in the future as a potent tool for the success of that endeavor.

There is an accompanying Instructor’s Manual and PowerPoint slide presentation available from Springer Publishing Company upon request at textbook@springerpub.com. Dr. Sydney Freeman, Jr., PhD, director of the teaching Center College of Veterinary Medicine, Nursing, and Allied Health at Tuskegee University assisted with the Instructor’s Manual.

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Lastly, thanks to the Almighty God for allowing such a publication to come to fruition, so that it can be used as an additional tool in edifying public health leadership, addressing the social determinants of health and improving the public health and well-being of disparate cultures and communities globally.
I ESSENTIALS OF COMMUNITY HEALTH PRACTICE

1

Fundamental Core Concepts in the Community Engagement, Organization, and Development Process

Frederick G. Murphy, Stephen B. Fawcett, Jerry A. Schultz, and Christina Holt

LEARNING OBJECTIVES

What you can learn by studying this chapter:

■ How to define basic concepts in creating community profiles
■ How to define basic concepts in establishing relationships with community gatekeepers
■ How to define basic concepts in building credibility
■ How to define basic concepts in developing a Community Coalition Board (CCB)
■ Why it is important to work with the CCBs to conduct a health needs assessment
■ Why it is important to collaborate with CCBs for development and implementation of community-based health programs
■ How to compare the Transtheoretical Model (TTM) and stages of change with Community Engagement, Organization, and Development (CEOD) change strategies
■ Why it is important to develop and sustain CCBs

The work of community health and development is both science and art. On the one hand, it grows from the lessons and experiences learned by community activists and professionals in trying to create public systems, programs, interventions, and policy that improve the lives and health of everyone in the communities targeted. On the other hand, it stems from the passion for social justice, equity, and fairness that can lead to the creation of truly healthy communities where all citizens, regardless of their backgrounds or circumstances, have what they need.

Commitment to community does not rise out of nowhere. It comes from and is guided by values, principles, and assumptions that spring from our backgrounds and cultures, from our experiences, and from our conscious
decisions about what is right. These values, principles, and assumptions shape our vision of the world as it should be, and motivate us to try to make it so.

The purpose of this first chapter is to provide a practical framework for the CEOD process, and for the more concept-specific chapters that follow. The foundation of that framework is a set of values, principles, and assumptions that inform a view of community health and development for public health practitioners. Concepts expressed are drawn from “real-life” grassroots community experiences and from theoretical and policy developments at public health institutions including Morehouse School of Medicine, Georgia State University, Emory University, University of Pittsburgh, University of Kansas, and many others.

CREATING A COMMUNITY ECOLOGY

Learning and analyzing the community ecology (CE) should be viewed as the initial step in the CEOD process. This step will assist the community organizer or public health professional to gain preliminary knowledge about the community they are seeking to enter. This knowledge comes in the form of compiled data and information, which can, subsequently, assist in the selection and development of meaningful evidence-based health promotion and disease prevention programs.

Community Entry Planning: Before beginning to document the CE, one should make a list of the types of preliminary information/data that could be most beneficial in forming subsequent community entry strategies. In other words, first enter the community “on paper” or “electronically” by documenting clearly the community’s geographic, demographic, economic, and political parameters. The Internet can be a vital source today for this discovery process. Community archives, if available, can also be a useful source. Although many communities are similar in their ecology, each one should be viewed as unique during the initial information-gathering process, so as to avoid predeterminations or community profiling. Communities are constantly changing these days, so ongoing information updates about them can be very useful. Some useful CE information that should be gathered initially includes the following:

- **Community Mapping**: Study an existing map of the community, or develop one, that lays out its geographic boundaries. The map should include as much detail as possible—not only street names but also the directions and distances of these streets (i.e., which ones dead-end, which ones run north, south, east, and west). Also, information should be compiled on the names and locations of churches, housing projects, community centers, hospitals, health centers, businesses or business districts, and so on, throughout the community. State, county, and city government offices and municipalities can provide much of this information.
1. **Community Engagement, Organization, and Development Process**

- **Population and Demography:** Demographic data should be collected including: age ranges, sex, racial/ethnic distributions, income levels, education levels, disease prevalence rates, and the like. Health departments, state, county, and city government offices and municipalities can provide much of this information.

- **History of the Community:** How long in existence and why established (refer to the community archives).

- **Formal Leadership:** Make note of exactly who the elected officials are that represent the community. If they have office space in the community, note the location on the map. Also, identify their political affiliation/party and their pet issues.

- **Informal Leadership:** Note the names of key residents and community activists residing in the community (most times nonelected). These leaders may become more identifiable later as one mingles and becomes more involved in the community.

- **Business Establishments:** Note names of business owners, types, and numbers of businesses in the community and where they are located.

- **Transportation System:** Identify what types of public and private commuter systems run in and around the community, including their schedules and routes.

- **Churches:** Note how many and the types of churches (i.e., denominations, name of leadership, etc.). Identification of church leadership will prove invaluable throughout the CEOD process.

- **Community Centers:** Note how many, the schedules, and the types of services offered.

- **Community Organizations:** These may be general neighborhood improvement organizations that any resident might join, or special interest organizations focused on education (e.g., parent teacher associations [PTAs]), recreation (e.g., sports teams, book clubs), business associations, or social clubs.

It should be noted that the CE does not, nor should not, stop with the collection of the above items, many of which are available in archived formats. Once the community organizer or public health professional physically enters the community, a whole new level of information gathering should emerge that provides even more in-depth knowledge concerning the community’s ecology. This information comes from mingling in the community and having one’s ear to the ground and immersing oneself in the community on an almost daily basis.

Examples of additional ongoing strategies for determining and documenting the CE in even more detail are as follows:

1. **Windshield/Observational Survey:** This involves riding or walking through the community at various time periods (morning, mid-day, evening), to “observe” who is doing what, when, and where. Notations
are made and added later to the notes previously taken during the preliminary descriptive CE phase.

2. **Listening:** This involves visiting business establishments and other community institutions (i.e., barbershops, beauty salons, churches, transportation system, etc.) to listen to what members of the community have to say about their community. It may involve riding public transportation through the community during different times of day to listen to conversations and watch behavior patterns. These observations provide “community awareness” like no other.

3. **Informal Engagement:** This involves taking proactive approaches to spontaneous conversation(s) with community residents about their community. This spontaneity can only occur if one is in the community on an ongoing basis and will almost always result in identification of informal gatekeepers. To show respect to the resident, one should only make mental notes during this engagement, to be written down later.

4. **Formal Engagement:** Involves formally contacting community leaders (gate keepers), respectfully seeking scheduled visits with them in their offices, places of business, residences, or in any other setting they designate. In some cases, telephone calls will suffice; however, face to face contact is always recommended, as it is the most effective method of engaging when seeking to build trust. Telephone contact can be the most practical and time-sensitive means of following up, after face-to-face contact has been made, or when this is the only method of engaging.

**Note:** To be “fully engaged” with a community, on a formal or informal level, calls for a preparation and involvement. Such engagement means working with communities to truly assist them in public health awareness and education. This can be done through a variety of methods, whether it be through town hall meetings, focus group sessions, one-on-one interpersonal dialogues, or a long-term community intervention project.

Any written account and analysis describing a community’s ecology should, at a minimum, include information about each of the areas cited above. Such introductory descriptive information will serve as a foundation for choosing subsequent evidence-based intervention activities. The CE description serves as a prerequisite to community entry, and can be as lengthy as necessary depending on identified needs. In some cases, thorough CE documentation can take 1 year or even longer to complete.

Taking the time to develop a good CE description is as close as a community organizer or public health professional can come to getting a birds-eye view and/or prospective vision of the challenges and potential social capital awaiting them. A successfully composed and well-studied CE can serve as a priceless tool for planning in the short and long term. It could very well be the difference between success or failure when seeking to form relationships and to gain an initial trust with community members.
Again, CE documentation will prove extremely useful in the development of community health intervention programs.

A thorough study of the particular community that needs to be engaged and organized will disclose to the community organizers/public health practitioners whether they need to approach the community as a “virgin community” that must be organized from the ground up, or whether a modified approach is needed that takes into account the existing individuals and/or organizations with advanced levels of maturity and activity.

**ESTABLISHING RELATIONSHIPS WITH COMMUNITY GATEKEEPERS**

The CE phase of the CEOD process is inseparably linked to that of establishing and building relationships with community gatekeepers. In many cases, community organizers or public health practitioners are new, or outsiders to the communities they seek to enter. Therefore, having as much background information on the community as possible can help catapult one forward in the relationship-building process. Studying this preexisting information beforehand can help to spark dialogue with community leadership, especially when one is just starting out, creating instant comfort zones between parties. However, when the public health practitioner starts the process of seeking long-term, established relationships in the community the “community entry process” truly and formally begins.

Examples of some useful strategies for establishing relationships with community leaders include the following:

1. **Making Introductory Contact:** The public health practitioner’s initial introductory contact with community leaders (formal and informal) many times may have to first occur via telephone. However, follow-up face-to-face meetings should be scheduled as soon as possible. Proactively reaching out to community leaders will inevitably serve as an “ice breaker” and the conduit through which tracks are laid for building trusting and credible relationships. This critical period of initial engagement can be a delicate time in the relationship-building process, and can serve as the platform from which “word of mouth” spreads concerning whether the community will “trust or distrust” the public health practitioner’s efforts. Tact and respect are the ticket here.

2. **Sharing Talking Points:** Sharing specific talking points about the community, many of which can be drawn from the CE process, can lead to an increase in confidence, relaxation, and the genuineness needed to move toward building credibility and trust. Credibility and trust are the true catalysts of the building relationship process, and will only be realized with time, ongoing community involvement, and by showing tangible deliverables to community leadership. Public health
practitioners or health professionals should present themselves as “servant leaders” and clarify to community leaders their rationale for entering the community.

3. **Relationship Listening:** Listening in this context, different from that mentioned in the CE process, is of a more intense nature and may involve asking for permission to take notes while engaging. The listening that takes place during this initial step in relationship building involves prudent speaking intervals. This listening has a specific goal of building trust. Listening shows respect. It projects the perception that what is being said by the gatekeeper is valued and important. Also, by listening and making mental notations, one can further add to the information/data-collection inventory started during the CE process. So then, this intense listening is especially important when engaging with the informal gatekeepers such as community residents.

Examples of some key community gatekeepers with whom relationships should be established include the following:

- Elected officials
- School officials and PTA leaders
- Clergy
- Directors of community centers
- Leaders of clubs and organizations
- Social workers
- Health care providers
- Council persons
- Neighboring Planning Unit (NPU) ward, or precinct chairpersons
- Community activists
- School principals
- Church pastors
- Social workers
- Business owners

### BUILDING TRUST AND CREDIBILITY

The public health practitioner should always show respect for the core values and beliefs of the community they are seeking to enter.

Credibility and trust are the essential factors in the relationship-building process, and should be seen as the glue that holds things together. Examples of key considerations when attempting to build credibility with community leaders/members include, but are not limited to, the following:

1. **Respect, Credibility, and Trust:** These are the most essential interwoven ingredients in the relationship-building process. These underpinning elements must be established before one can effectively proceed
toward developing a CCB. They can only be achieved, however, by genuinely getting to know people. These come with time and involvement, so quite frankly stated: “if no time, engagement and involvement is spent in the community... no respect, credibility or trust will ever be built.”

2. **Building Interpersonal Relationships**: If credibility and trust are to occur, it will be important for the community organizer/health professional to have established interpersonal relationships with key individual community members and leaders. Again, this takes time to build, and will only happen with ongoing tactful face-to-face engagement/involvement. Showing genuine concern about the individual’s and community’s well-being can be an invaluable first step toward building a trusting relationship. As mentioned previously, public health practitioners should present themselves as “servant leaders” and clarify their role in providing technical assistance in the CEOD process.

*Example:* One must routinely visit community members’ homes (when invited), offices, and places of business, and so on. Many times, community members become involved in a community group or organization just because they have a credible and trusting relationship with another person who asks them to participate.

Further, while seeking to establish relationships throughout the community, it will also be important for public health practitioners to express that they are also there to learn, as well as to share. This is where reciprocity (give-and-take) can be an important asset, as many times community leaders/residents will more readily accept help if they know that they too can share and educate in some fashion. The public health practitioner’s role as “helpee” can prove very important to the trust-building process.

3. **Referrals**: As initial relationships are established, referrals will be made across the community from “one community leader to another community leader” (horizontal referral). This is a very important step in the process of building community credibility, as these types of referrals may open doors leading to trust and credibility that would otherwise remain locked to an outsider for indefinite periods. Such referrals can save days, months, even years in the credibility-building process.

*Example:* To be able to name drop that: “Mr. Smith or Pastor John” recommended that I “call you or come see you” could add tremendous value to the initial contact. Many times, trust relationships are accelerated because of such “across community” referrals.

4. **Community Participation**: It is also important to “show up” and participate in scheduled and unscheduled community activities. This includes attending community activities that have nothing specifically
to do with health or the leading causes of death and was not initiated by the public health practitioner.

**Examples:** attending worship services or Little League games, or working out once or twice a week in the community center, or attending a neighborhood meeting when invited, and so on.

5. **Identifying Resources:** Credibility can be further enhanced by assisting the community to conduct some of its preplanned community activities. Many days, and even months, may have to be spent in this effort. A general principle applicable to both this and later stages of the CEOD process is: **It is essential to address the community’s priorities first.**

**Example:** This may mean assisting the community to locate resources (i.e., individuals, materials, funding, etc.) that will help it to successfully hold a block party, or purchase jerseys for the Pee Wee League football or basketball team, or sponsor a community-sponsored fashion show, and so on.

6. **Initiating Community Activities:** The public health practitioner can volunteer to assist community members to plan and conduct a health-related activity. In doing so, the public health practitioner can identify and arrange for professionals (vertical referrals) that have specific skills and trades to participate. For example, they may recommend that the community hold a health fair or block party. Here, the public health practitioners can recommend and identify the health professionals and other resources for participation.

Lastly, it is worth repeating here that, in order for the CEOD process to have a chance, there must first be **trusting and credible relationships** formed. When trust is missing a Community Coalition Board will have little chance of coming to fruition, and even if it does, its members will have a difficult time functioning cooperatively over time. Conversely, if credibility and trust exist throughout the coalition-building process, they will serve as invaluable ingredients to the coalition’s sustainability and resilience when or if conflict arises. If trusting relationships (vertical and horizontal) are already in place, all will be in a better position to help solve conflict and misunderstanding that will inevitably occur, over time.

**DEVELOPING A CCB**

One of the primary purposes of the CEOD model is the edification and sustaining of communities. Community edification should be defined as the building of communities through health education, training, and skill development. Further, to edify is building up and empowering of
communities through community involvement and by demonstrating that one truly cares for those residing and working in the community.

A CCB is a group of individuals with a common interest who agree to work together toward a common goal. Further, a truly empowered or edified CCB is one that becomes a formally “incorporated” organization with a mission statement, bylaws, a governing body, community responsibilities, funding, and sustainability. The CCB may also, eventually, serve as a community employer when it has identified funding for specific health programs. Again, its primary purpose for existence is to create and/or support efforts to reach a particular set of common community goals.

Here are some key fundamentals used in the initial CCB development process. These steps may include the following:

1. **Start with people you know:** Make a list of those community leaders and gatekeepers with whom relationships and credibility have already been established (see previous section on CE process). Persons with whom there is an “established credibility and trust” are usually important to choose from for CCB membership, since they can be more easily persuaded to participate than individuals with whom there is no established relationship. In addition, they may have additional reliable referrals that can be pulled into the recruitment circle. This group of people can also serve as an informal “advisory committee or steering committee” and may play a key role, short and long run, in the unfolding of the CCB process. Beware, however; some of these same folks may opt not to stay on after the CCB is formed.

2. **Identify other important potential CCB members:** In almost every community there will be various other formal and informal leaders with whom you have made no contact. These individuals may already have ongoing programs and activities launched in the community. For example, The coach who is attempting to raise funds to purchase jerseys for the Pee Wee League team he has established, or the lady who has decided to pull together a block party to promote neighborhood clean-up, or the pastor who has planned to have a community benefit dinner in the basement of the church to raise awareness of HIV, drugs, or teen pregnancy prevention. These individuals are using the resources they already have at their disposal to improve the community, but each may fall under a different community umbrella as far as their community goals are concerned. The CEOD CCB concept seeks to bring these leaders under one formally structured umbrella to collectively partner, while reaching community goals. It will be important, therefore, to persistently seek them out. These persons, once on board (“buy-in”), tend to have staying power.

3. **Beginning the formal CCB recruitment process.** Once a well-thought-out list of potential CCB members has been formed, and thoroughly reviewed by the CCB, the formal recruitment process begins. Depending on the programs and activities proposed, there will be
persons or organizations identified as essential for membership recruitment to the CCB. Although it is important to start with the individuals and groups mentioned above, an open mind should be kept during the process, because new referrals and ideas will continually emerge. The core advisory group of community leaders can be very important to the recruitment process, as they may know many other potential members personally, and can make immediate contact with them. They may give the invitation to join much more credibility and may reduce recruitment time for the public health practitioner by hours, maybe even days. However, CCB recruitment efforts must be closely monitored, on an almost daily basis, to ensure that things do not get out of hand and that inappropriate individuals are not accidentally or unintentionally recruited.

Below are listed some of the key methods for contacting individuals and organizations for recruitment. These are listed in their approximate order of effectiveness. Face-to-face contact is the best approach; however, it also takes more time and effort and should be reserved for those individuals most important, or most difficult, to recruit.

The listing is as follows:

- Face-to-face meetings
- Phone calls
- E-mail
- Personal letters
- Mass mailings
- Public service announcements or ads in the media
- Flyers and posters

In almost every community a combination of these recruitment methods is recommended for use.

**FORMALIZING THE CCB STRUCTURE**

Without fail, communities will have preexisting landmark organizations, which have served as bedrocks to the community’s history and culture. These could come in the form of tenant- or faith-based organization, or PTAs, and so on. For example, the church has served as the key to respect, justice, and beneficence, especially in many low-income and African American communities, the CCB may, however, be that new organization that brings about a renewed focus and structure for public health activities in the community.

Therefore, before formalizing the CCB, it is critical to capture whether or not there is “buy-in” to the overall CEOD CCB concept by the key gatekeepers/community leaders. This buy-in, in most instances, is usually a seriously expressed verbal commitment to becoming partners or
members to a formalized structured CCB. A formal meeting should be called between the organizer/health practitioner and these leaders. This meeting should have a set agenda, which leaves room to lay out all intentions, and brings to the table a “full disclosure type atmosphere.” Only after all participants have bought in, should a formalized development process of an incorporated 501(c) 3 CCB be pursued.

Reasons why it is important for a 501c (3) CCB to be developed include the following:

- A CCB provides a structured community health driven “culture/environment” for building cooperation and trust between its members. It can give added value and identity to individuals and organizations that join the group, as well as to the group itself.
- It provides a “corporate structure” and gives the group the opportunity to establish: (1) a community-based mission statement, (2) corporate bylaws, (3) organizational guidelines, (4) an arena for bringing together “community partners” under one umbrella to address community health concerns, (5) a structured environment for resolving community disagreements, and (6) the social capital needed to maintain and sustain community culture and investment.
- Sets “roles and responsibilities” so that all members are accountable to each other and to the activities they pursue. No one person and/or group will make decisions in a vacuum but in the best interests of the community and the CCB.
- Creates a structure where “rules, bylaws, and oversight” are established. Officers are elected, agendas are set, and Robert’s Rules of Order is used to conduct meetings. Norms (checks and balances) emerge as part of the organized “CCB culture.”

**An Alternative Approach to Traditional Bottom-Up CEOD**

**“Top-Down Approach”**

The 21st century has broadened and introduced many new public health challenges including natural disasters, pandemic outbreaks, record unemployment, increased number of uninsured and underinsured, as well as a rise in many other social determinants that impact health status. Emergency preparedness has become one of the top public health concerns. All of these have caused leaders to rethink how they approach public health issues at local, state, and global levels.

The complexity of these social determinants brings about the need for immediacy in organizing partnerships to readily address pressing community risk factors. These partnerships are determined by the institutions’ service structure (the types of services they provide), their political position in the community (state vs. city government, etc.), and the degree to which all partners are currently engaged in the partnership’s activities.
It is essential to **build partnerships** to address social determinants of health because no one group, be it health care providers, public health practitioners, or community members, can accomplish the many tasks required for changing social, economic, and environmental conditions that impact health. Tapping into existing partnerships provides instant knowledge and brings experience to the table concerning services that can realistically be addressed. However, although existing groups are important, they may not address all the social determinants of health or include people or organizations from the community who can inform initiatives to address social determinants. Therefore, it is important to invite others to join your efforts, particularly those who have insight into or experience harm from the political, social, economic, and environmental conditions in the community.

Listening to the voices of people who belong to organizations in the community who have previous experience in the equitable distribution of social, economic, and environmental resources can help to build a strong partnership to address social determinants of health inequities. Together with other members of the community, they can assist to identify important nontraditional partners, and to help make a list of the other relevant sectors of the community (e.g., government, education, business, public services, faith, funding agencies) and help ensure that your partnership includes representatives from each of these sectors, as well as other appropriate community members. To effectively identify those who may be interested in the work of your partnership, it may first be necessary to consider how your community is defined (see also CE section).

**WORKING WITH THE CCB TO CONDUCT A HEALTH NEEDS ASSESSMENT**

In many instances, CCB members may have preexisting knowledge, information, and experience in issues of health and wellness. They may already know the causes and risky behaviors existing in their community for diseases such as violence and HIV, and may have already participated in informational campaigns about specific health issues and their consequences. Many community residents may have already learned about many health issues from radio and TV commercials, the Internet, public service announcements, newspaper articles, and other sources. The information accessed through these campaigns, while useful, may not always be specific enough for use by a community group trying to solve health disparities specific to its target area.

The best way for the community to get relevant and updated health information is to develop and implement an organized “health needs assessment” that is community driven. This assessment can provide
detailed information about the needs of its residents, and will identify resources available to the community to help solve those needs. Therefore, the public health practitioner should first provide an orientation to the CCB about the “value added” by conducting its own community needs assessment. This orientation should include, at a minimum, the importance of such things as:

- **Understanding the community environment**: Mapping the resources and limitations of the area. The previously developed CE tool can be a valuable start here.

- **Knowing what the community thinks and feels**: About health issues and what they think needs to be done about it.

- **Setting priorities for programs or system improvement**: It should be brought forward to the CCB how much easier it will be to make informed decisions and set priorities if a comprehensive identification of needs and resources has taken place. For example, an assessment can help more truly identify those community persons who are in most need. It will help to gain fresh data and information from the people who are directly experiencing the problem, allowing them to openly discuss their health needs.

- **Identification of health care/service providers**: Knowing the health care organizations and providers that serve, or could potentially serve, the community can be useful to the CCB in conducting evidence-based public health intervention programs.

- **Potential community health leaders**: Once the CCB has a complete picture of the health needs and resources of the community, they will have the knowledge base to become community leaders or “servant leaders” and to make informed health-related decisions, to explain actions, even to eventually write grants and lobby for the organization.

### Choosing an Assessment Method—Preliminary Steps

- **Determining assessment feasibility**: Preliminary steps should be taken by the CCB to select an appropriate community assessment methodology, as this is not a “one size fits all” deal. Therefore, it is important for the CCB to evaluate thoroughly the amount of resources available to them, as this has much to do with which method can feasibly work. For example, “face-to-face interviews combined with telephone surveys” could be an excellent combination, if there is a large enough budget.

- Regardless of the method desired, it is important to first take into account some reality factors, such as:
  - The amount of time available
  - The number of people available to conduct the assessment
  - Available resources (i.e., funding, materials, etc.)
  - The size and characteristics of the target population(s)
Therefore, the public health practitioner can assist the CCB to first take some basic preliminary steps, prior to identifying and conducting a formal community assessment. Examples of these steps could include:

- **Brainstorming with CCB members**: The public health practitioner can recommend the CCB to take a very practical first step: think and talk about what information really needs to be gathered during the assessment. Will the assessment seek to gather a panoramic/overall view of the health needs of the entire community, or only a snapshot of specific disease areas and/or services? Identifying the “specific data/information needed” is a key first step for the community.

- **Reviewing of existing CE data/information**: After determining the specific data/information needed, the CCB should review the CE and other preexisting data sets (i.e., health departments, census data, etc.). This review can be a time-saver. It can also help highlight what data do not exist. This review will be very useful in subsequently determining what type questions need to be included when developing the assessment tool(s).

- **Identification of the target population to be assessed**: After the brainstorming and existing data review are completed, the public health practitioner should sit down with CCB members to determine what are the purpose of the assessment and the method of the assessment. Also, this would include such ideas as: whether households will be assessed by randomly going to homes such as every other household, or only assessing so many households per block, and so on.

- **Formulating appropriate assessment plan**: Once the preliminary steps have been completed, an assessment plan should be developed. This would include the when, the where, the how, the who, and so on for implementing the assessment. Appropriate questions and formats are developed, and strategies drawn up. In most cases, institutional partners on the CCB with expertise in conducting assessments should be called upon. The public health practitioner can help identify these experts if they are not already part of the CCB. It will be important that the questions are appropriately formulated (i.e., culturally sensitive, proper reading levels, etc.) for use with the group(s) to be assessed.

**Potential Survey Methods**

Other than the 501(c) 3 phases of the CEOD process, accomplishment of a community assessment can serve as first official “team act” of the CCB. The accomplishment of this most important, organized, team-oriented task can do wonders to boost the confidence and sustainability of the CCB. CCB team involvement in this process should range from planning, to training, to data analysis, and ultimately to compiling the health-related findings. They should be encouraged to feel that they are individuals involved in a specific project to yield a distinctive product.
The public health practitioner can bring to the CCB several alternative methods and strategies for conducting the community assessment. However, it should be noted again that institutional partners with expertise in conducting assessments (i.e., universities, health department staff, private agencies, etc.), some of which may be represented on the CCB, should be called upon to assist in this process. Survey methodology can be a complex science. Therefore, a compromise may need to be made between what is acceptable scientifically and what a small organization can afford. The assistance of a scientific professional with experience in conducting surveys can be very useful.

There are several assessment methods to choose from and there is no one perfect method. In some cases, depending on resources available, a combination of methods is better than just one. Here are a few standard methods a public health practitioner, or the experts, can bring to the CCB for consideration:

- **Community Forums**: This method can provide community residents of diverse backgrounds the opportunity to openly express their views. Keen listening and recording of minutes are essential during the implementation of this method. This form of assessment provides data and information that facilitates “learn first hand,” the community’s perspectives on health, as well as other community resources, concerns, and ideas. Forums may be the most appropriate method, particularly for communities where there may be some residents who have difficulty interacting and/or reading self-administered printed materials. This method could be most successful if conducted during a regularly scheduled community meeting at which groups gather routinely to discuss community issues. The CO, or CCB member, can ask permission to be placed on the agenda.

- **Face-to-Face Interviews**: The use of this method can be especially valuable in communities where disparate and low literacy rates are high. In communities where significant numbers of residents have difficulty reading printed materials, or where more in-depth answers are required, the face-to-face interview method can create the dialogue needed to gather information from these participants.

- **Phone Surveys**: Telephone surveys can have similar benefits to face-to-face interviews; however, for communities where there exist low-income populations, telephone access may be limited. This would mean very low encounters and could cause extreme frustration to the assessment process. Also, unless your “community” is represented by an entire area code, or phone numbers are assigned in such a way that they can be associated with your community (for instance, if all phone numbers in the community have the same first three digits), your needs assessment may be more far-ranging than you intend.
Self-Administered Questionnaires: This method may be best utilized when dealing with respondents who can easily read the questions and write. It can be used when asking for information that does not require interpretation, or explanation charts, graphs, and so on.

Direct Mailings: Direct-mailed surveys to people whose addresses are known is the most common strategy. However, in many communities, this method has a low rate of response. Direct-mailed surveys are, of course, self-administered, and so the rules relevant to self-administered questionnaires apply.

Convenience Sampling: Taking surveys in a public place—setting up a booth or table in at a barber shop or beauty salon, a church or in a parking lot at a local discount store, on the sidewalk in the shopping district, and so on—provides an opportunity to get some exposure for your organization as well as a sample of public opinion.

Group Survey Administration: This method, as with community forums, could be most successful if conducted at an organization or precinct meeting where there are large groups gathered. The public health practitioner, or a CCB member, can request the chairperson’s permission to be placed on the agenda for one or more meetings, as needed. At the meeting, the assessment could be introduced, the purpose explained, and the survey instrument distributed and collected.

Training of Potential Interviewers

The public health practitioner should organize a formal interviewer training workshop. While such training is a must for potential interviewers, it also has a built-in weeding out process that will determine who can truly succeed as an interviewer. Everyone who participates in the training may not be appropriate for the task. Thus, the interviewer selection process must be handled delicately and tactfully, as hurt feelings and resentment can come into play here, subsequently causing serious damage, possibly even setting back the CEOD process.

Below are some examples of a few topics, which could potentially be covered during the CEOD interviewer training:

1. Orientation: Providing potential interviewers information about the survey, its purpose, and the overall mission and goals of the CCB. This can also ensure that the information they pass on to respondents concerning the CCB and the assessment is uniform and accurate.

2. Safety: The importance of interviewer safety while conducting interviews, especially for face-to-face household interviews, and so on.

3. Importance of Etiquette: Regardless of the method chosen, interviewer etiquette and respect should be emphasized. For example, the importance of simple gestures such as saying please and thank you cannot be overstated. Respect for the community and its residents should be emphasized during this section of the training workshop.
4. **Potential Termination of Interviewers:** Emphasis should be placed on the importance of confidentiality, accuracy in completing surveys, honesty and reliability in survey completion, and so on. However, interviewers should be made to understand that if one or any combination of these requirements is found to be lacking, they may be asked to withdraw from participation.

5. **How Surveys Will Be Gathered:** Indicating the when, where, how, and who, about collecting incoming surveys as they are completed.

6. **Review and Verification of Completed Surveys:** Indicating to potential interviewers how checking and verification will take place to ensure interviewer honesty, completion, and reliability.

7. **Data Analysis and Translation:** This will be an essential part of the assessment process and will require institutional experts to compile and analyze. However, information and data analysis must be done in a practical manner for ease in translation and interpretation. CCB members, regardless of educational background, should be able to understand the results of the assessment. This will call for “mixed translation methodologies” for presenting data and information taken from the survey. Thus, the analysts must first “do their homework” in understanding the CCB target audience, clearly understanding the goals of the CCB, and gaining a sense of the skill required to effectively translate the results.

Finally, the community assessment process represents a key step in the CEOD process. Its critical nature should be continuously highlighted to CCB members, some of whom may be interviewers themselves, as an important team accomplishment. Other than the 501(c) 3 incorporation phase of the CEOD process, the community assessment will serve as first official team activity of the CCB.

### COLLABORATING WITH CCB FOR DEVELOPMENT AND IMPLEMENTATION OF HEALTH-PROMOTION INTERVENTIONS

**Collaboration, Inclusion, and Engagement**

Once the assessment phase is completed, and the results analyzed, and fully understood by all CCB members, the CCB can begin to discuss and decide to take action by designing a community health-promotion intervention. The public health practitioner should seek to further build the CEOD process by developing formal meetings that calls for “collaboration, inclusivity, and engagement” by all CCB members. The public health practitioner can facilitate this by inviting all CCB members to the table and establishing agendas where members have the opportunity to have input into planning and design of a community health promotion intervention program. This may take time, requiring several meetings,
in order to give all members ample time to gain respect and share their viewpoints.

However, implementation of this inclusivity in a real-world environment has shown that such attempts do not always work out. Some people might, for one reason or another, opt out of the process. In some of these situations, a persistent attempt at inclusivity can cause its own problems. Be that as it may, this does not preclude giving all members the choice to express themselves in the intervention planning process.

In brief, here are a few examples of eventual benefits to CCB involvement in the community health-promotion intervention planning process:

1. **CCB Ownership:** Through involvement in planning of a community health-promotion intervention, CCB members begin to move to an even higher level of “ownership” and begin to feel that they will do whatever they can to see their work succeed.

   In the CEOD process, it has also been learned that in most low-income, high-disparity, or minority communities, individuals and groups feel that they are talked down to and/or not listened to, even when they are asked for their opinions. True involvement then calls for “dialogue” with and between members, discussing in a respectful manner methods and strategies to be used. Many times this means having respectful debates about what should or should not be done in the intervention. “Rubber stamping” ideas presented by CCB members just because they are community members or low-income and/or minorities can, in some instances, lead to reverse condescension, as if anything they say must be accepted as true and appropriate. Thus, a truly community-engaged intervention planning process means listening to everyone, but being prepared to disagree over ideas and goals, and to wrestle with new concepts.

2. **Credibility of the Intervention:** Because the intervention was planned by the CCB members and representatives of the community, other community residents will more easily respond to participating in the community health-promotion intervention activities.

3. **Reduces Possibility of Intervention Failures:** Involvement of CCB members in the community health-promotion intervention planning process can help bring forward the many values and norms specific to the community’s culture. For instance, scheduling interventions on days when many community members are awaiting financial or food assistance checks to arrive in the mail, and so on will almost always guarantee high rates of “no shows” for recruitment and participation. Many CCB members will know what strategies have failed in the past and why, and can keep the intervention program developers from repeating past mistakes.

4. **Key CCB Members Buy-In:** Because of their involvement in the intervention planning process, CCB members identified to be “key players” many times make commitments to future cooperation, simply because they have been included in the planning from the beginning.
5. **Teaching Planning Skills**: The community health-promotion intervention planning process can help to improve the community over the long term. CCB members can learn to run meetings, to analyze data, to construct strategic plans—in short, to become community resources and leaders.

6. **Increases CCB Trust**: CCB member interaction in the intervention planning process, especially between community members and business leaders, can be not only be supportive of the intervention, but may help to create long-term relationships among members. This trust can serve as a foundation for future community development and community action.

In conclusion, collaboration, inclusiveness, and empowerment, embody the ideals that form the foundation of a true grassroots, community-based CEOD process. It respects everyone’s intelligence, values everyone’s ideas and experience, and affords everyone a measure of control. By empowering the community rather than imposing preexisting ideas of academics or public health professionals, one can assure an ethical approach to planning an evidence-based community intervention.

### Designing the Community Intervention—Plan of Action

#### Asking Important Preliminary Questions

Before the actual designing of the community health intervention begins, the CO/health educator should assist the CCB in developing an intervention **action plan**, which can be extensive. In short, the public health practitioner should assist the CCB to ask and answer the following questions:

- **What potential barriers** exist or can be anticipated in the community? How can they be minimized?
- **What resources** are available and needed (i.e., financially, politically, time-wise, and kind)?
- **What intervention components** should be implemented?
- **Who** should coordinate and implement **programs**?
- **When** should programs be scheduled (i.e., **mornings**, **evenings**, **noon**)?
- **What partnerships with individuals or organizations** need to be formalized?
- **What interventions programs** have already **worked** and could be replicated?

### Identifying Core Intervention Program Components

Identifying appropriate **core program components** for the community health intervention will be the true nucleus of the intervention design. The public health practitioner should encourage the CCB to consider these core items closely when designing the intervention plan. This calls for the CCB to lay out appropriate, feasible, and culturally sensitive programs by its
leadership. The CCB should identify, as closely as possible, appropriate, manageable timelines and activities that can be used in the implementation of the intervention. Examples include the following:

- **Identification of where** to hold the intervention programs (i.e., community center, church, school, etc.)
- **Identification of recruitment methods and strategies** for bringing in participants
- **Identification of which days and hours** to conduct the intervention activities
- **Identification of what culturally appropriate educational training materials** should be needed for each program
- **Identification of who** (staff/personnel) should coordinate/conduct the intervention programs
- **Identification of appropriate methods** for monitoring and evaluating program effectiveness (academic and private institutions can assist here)

### Maintaining the Community Intervention

A successful community health intervention, with evidence-based and evaluable outcomes can and, in most cases, will take time to realize. Just as with intervening with an individual one-on-one, a community intervention can go through stages of development that require patience and ongoing monitoring.

For example, the TTM of Behavior Change assesses an individual’s readiness to act on a new, healthier behavior, and provides strategies or processes of change to guide the individual through the stages of change to action and maintenance (see Figures 1.1 and 1.2). The public health practitioner will have to conduct ongoing periodic assessments of how the community as a whole responds to the new intervention program. Results from these assessments will help guide the public health practitioner to modify and revise the intervention to boost attendance and participation by the community. These “boosters” are vital to the ongoing maintenance, to the “upward spiral,” and to the sustaining power of the intervention and can be the difference between success and failure (see Figure 1.2).

Let us take a look at the six Stages of Change involved in the TTM and imagine for a moment similar stages being a Community Intervention Method (CIM) process.

- **Precontemplation:** “People are not intending to take action in the foreseeable future, and are most likely unaware that their behavior is problematic.”
- **Contemplation:** “People are beginning to recognize that their behavior is problematic, and start to look at the pros and cons of their continued actions.”
Preparation: “People are intending to take action in the immediate future, and may begin taking small steps toward change.”

Action: “People have made specific overt modifications in their life style, and positive change has occurred.”

Maintenance: “People are working to prevent relapse, a stage which can last indefinitely.”

Termination: “Individuals have zero temptation and 100% self-efficacy…they are sure they will not return to their old unhealthy habit as a way of coping.”

In general, as with the TTM, for community residents to take ownership and fully participate in a community health intervention, the public health practitioner will need to work with community participant to:

A. Develop a growing awareness that the advantages (the “pros”) of the intervention change outweigh the disadvantages (the “cons”—the TTM calls this decisional balance

B. Instill confidence that they can make and maintain changes in situations that lead to unhealthy behavior—the TTM calls this self-efficacy

C. Include the community in developing strategies that can help them make and maintain change—the TTM calls these processes of change.

The 10 processes are listed as follows:

1. Consciousness Raising: Increasing awareness via information, education, and personal feedback about the healthy behavior.
2. **Dramatic Relief:** Feeling fear, anxiety, or worry because of the unhealthy behavior, or feeling inspiration and hope when they hear about how people are able to change to healthy behaviors

3. **Self-Reevaluation:** Realizing that the healthy behavior is an important part of who they are and want to be

4. **Environmental Reevaluation:** Realizing how their unhealthy behavior affects others and how they could have more positive effects by changing

5. **Social Liberation:** Realizing that society is more supportive of the healthy behavior

6. **Self-Liberation:** Believing in one’s ability to change and making commitments and recommitments to act on that belief

7. **Helping Relationships:** Finding people who are supportive of their change

8. **Counter-Conditioning:** Substituting healthy ways of acting and thinking for unhealthy ways

9. **Reinforcement Management:** Increasing the rewards that come from positive behavior and reducing those that come from negative behavior

10. **Stimulus Control:** Using reminders and cues that encourage healthy behavior as substitutes for those that encourage the unhealthy behavior

While the comparison of the processes of this model to that of the CEOD model may seem an oversimplification of the task at hand for the public health practitioner, it can serve as a valuable template in the planning, designing, implementation, and evaluation processes of the CIM.

**CCB STRATEGIES FOR SUSTAINABILITY**

Sustaining the CCB can be a challenging venture as ongoing changes and even burn-out will inevitably occur. The CCB will need to develop resilience to withstand these changes. For example, ongoing changes can occur in the number and composition of membership and partnerships,
which are natural occurrences with any community-based organization for various reasons. Therefore, in order to maintain and sustain the CCB, its leadership must deploy ongoing strategies. This will keep members motivated and continue to build ownership and collective trust.

There are some key examples of strategies showing how this ownership and “stick-with-it-ness” spirit can be maintained and sustained:

1. **501 (c) 3—Institutionalization**
   Establishing and maintaining the nonprofit organization is essential to the CEOD process. This calls for ongoing identification and replacement of members, implementing new programs, ongoing development of new relationships, identifying new strategies and practices, and updating methodologies for approaching the community and the ongoing identification of resources. Thus, developing a plan for sustaining the 501 (c) 3 CEOD institution will increase its impact and perception in the community as an institution embedded there for the long run.

2. **Subcommittee Development**
   The creation of subcommittees allows CCB members to engage and plan for community intervention activities. These committees are where members can agree and disagree, all the while working together for common goals.

3. **CCB Education, Training, and Skills Development**
   Education, training, and skill building among CCB members are key components in the sustainability process. Such learning endeavors help to further motivate and build ownership among members.

   Through ongoing participation in learning programs, members will themselves become high-achieving community health innovators and advocates. They will also begin to encourage each other, and their partner organization members, to bring on new learning initiatives that will assist the CCB to grow.

   These learning efforts (i.e., education, training and skill building, etc.) can be achieved through various methods including: in-service courses, webinars, seminars, workshops, participation at conferences, and other learning experiences.

   The overarching goal, in all cases, is to make sure that everyone on the CCB has the opportunity to constantly be engaged in ongoing learning. This will be a key factor in the building and sustaining of a truly empowered CCB.

4. **Marketing, Partnering, and Resource Identification**
   Designing a CCB logo and developing an inventory of free giveaways can help in marketing the nonprofit groups. Partnering with other organizations is very important to the social capital network. This partnering can
occur in a variety of different ways, from writing grants together to the sharing of resources, such as:

- Time-share positions
- Office space and equipment
- Skilled staff persons
- Recommended volunteers
- Recommend student interns from academic institutions
- In-kind donations of time

Most of the items listed above can be categorized as *in-kind support*, which simply refers to resources *other than money* that comes available to the CCB.

5. *Grant Funding*
Seeking out grant funding is usually the primary method of acquiring financial sustainability for a CCB. These monetary grants may come from a variety of sources including local and federal government or private foundations. Each grant is usually awarded for the purpose of assisting in the implementation of a specific community intervention program or project.

6. *Fundraising*
Fundraising should be an ongoing part of the CCB agenda (i.e., quarterly, semi-annually, or yearly). Fundraisers usually require the CCB to provide a product, a service, or an event that will allow others to contribute money. Examples of fundraisers include bake sales, car washes, block parties, sporting events, and so on. In each case, the group charges money for a product to raise funds to support their cause.

**SUMMARY**

While the concepts shared in this chapter are by no means all that can be used to conduct CEOD activities, they are realistic and can be used as templates in the development of even better and more innovative CEOD approaches over time.

Public health practitioners will need to study and familiarize themselves with the basics before and after entering a grassroots community. Learning the do’s and don’ts of working with community residents, while identifying the “how to” of fusing oneself into the community in a trustworthy and passionate way, is most paramount. Preparation and patience go hand-in-glove in the CEOD-building process. The old adage of hurry up and wait turns out to be a realistic concept. It means knowing when to be aggressive, so as not have missed opportunities, yet knowing when to
be patient and prudent in the implementation of methods and strategies to avoid being disrespectful and presumptuous.

Knowing community is one thing, doing community is quite another! While this statement may seem an oversimplification of the matter, one only has to immerse oneself into community-based public health practice to realize the complexity that exists in successfully connecting the dots of the CEOD process. CEOD, in theory, may sound like a game of checkers, but, in practice, it is a high-stakes game of chess.

Case Study Exercises

Individually, or as a group, review the following case studies and follow the exercises suggested at the end of the study, as appropriate. Be sure to focus on the why, how, and what emphasized in each item. Your professor/instructor will provide you with specific guidance on how you are to report your findings for the class.

Case Study 1.1: Franklin County Health Department

In order to address the social conditions that lead to poor health, Franklin County is participating as one of the national Health for All Initiative grantees.

Franklin County public health officials recognize that the odds of being healthy can depend very much on which community you live in. Franklin County has been closely tracking inequities in health and using data on social determinants of health to inform community health improvement efforts. In-depth analysis of available census data has shown, in fact, that there is a 10-year difference in life expectancy between a child born in rural Franklin County and a child born in urban areas. The geographic area into which a child is born can also predict whether the child is likely to graduate from high school or the likelihood of developing medical conditions such as asthma.

Examining mortality and morbidity census data by urban or rural status shows gross, and growing, disparities. In fact, retroactive analysis has shown that the gap between life expectancy for urban and rural residents has increased since 1970.

Former Surgeon General, David Satcher, and his colleagues calculated that between 1991 and 2000 nearly 177,000 deaths were prevented because of advances in medical technology. The epidemiologist with the Franklin County Health Department calculated that if we were to eliminate the disparity between urban and rural residents, we would have avoided over 25,000 deaths.

Franklin County also examines the social gradient, which, in keeping with trends nationally, shows that the more income and wealth people
have, the more likely they are to live longer, while people with less income and wealth can expect to live comparatively shorter lives.

Public health officials in Franklin County use these compelling data in reports and presentations to raise awareness about these inequities and the importance of addressing conditions for health at a fundamental level. They used these data to underscore the need for capacity-building and to address these systemic issues. These data point to the multiple and interrelated solutions that must be put in place to begin addressing these inequities, including social policies that affect education, housing, land-use decisions, and economic development. It also points to needed modifications to the physical environment that influence health, including reducing exposure to mining toxins; increasing the availability of open space and healthy foods; decreasing the prevalence of stores specializing in fast foods, alcohol, and tobacco; and encouraging residential patterns that promote interaction across boundaries of race and class.

Study Items
1. Identify a target community or county of your own (real or fictitious).
2. Identify and describe what data you would look for that might help see the broader conditions of disparity that lead to disparities just as in Franklin County.
3. List what sources you would contact and use to obtain such data.
4. Describe how you would use this information to select interventions.

Case Study 1.2: AbilityLinks Increases Employment for People With Disabilities

Background

AbilityLinks, established to increase employment opportunities for people with disabilities, works to increase awareness of the value of hiring people with disabilities. Founded in 2001 by Marianjoy Rehabilitation Hospital in Wheaton, Illinois, AbilityLinks’s centerpiece is its award-winning website—www.AbilityLinks.org—which brings together businesses and job candidates with disabilities and is backed by AbilityLinks staff who provide ongoing support to website users.

AbilityLinks, a consortium of approximately 150 businesses, nonprofits, and government agencies, holds periodic planning sessions to review its vision, mission, and objectives. These include advisory board meetings (three to four a year) and a more inclusive strategic planning session involving all the stakeholders held every year. One such planning session, “Charting Our Course for the Year Ahead,” held in May 2004 was facilitated by an outside consulting firm. Participants looked
carefully at past accomplishments, identified key focus areas for the consortium, clarified priorities, and defined committees needed to achieve these plans.

At this strategic planning meeting, the consortium considered many issues to ensure the project focus stayed on its mission to increase employment of people with disabilities. They determined that the vision, mission, and objectives are still relevant, but AbilityLinks had evolved beyond the start-up stage and was ready to progress to the next stage of self-sufficiency. Further and continuous planning was critical to continue to move the consortium forward. Such planning began at this meeting as the consortium reviewed previously established goals and strategies in more detail and recognized the need to restructure the committees to better fulfill the vision, mission, and objectives. Committee restructuring and developing work plans for the new committee became the focus of this planning meeting.

The consortium uses committees to carry out many of its actions set forth by the objectives, while AbilityLinks staff continue to carry out actions related to finance, administration, and website development. Because of the consortium’s committee structure, membership becomes a critical element and likely stumbling block. Now, the AbilityLinks consortium has a strong, representative membership that it needs to use effectively, which requires continuous communication and meaningful involvement. Members may participate regularly or intermittently, depending on their organizational connection and time availability. The only foreseen concern that may hamper working relationships among consortium members and AbilityLinks relates to turf issues and competition for job placement and job leads.

Consortium members suggested ways to better manage the committees and membership in order to ensure active participation. They decided to form fewer committees with more membership represented on each committee in order to ensure that each committee has enough active participants to be successful.

Expanding and using the membership effectively involved tracking those who expressed interest in joining the consortium. In the past, businesses and service providers had signed up to be a part of the consortium, but were not contacted in a timely manner to become involved. Sophisticated record-keeping, tracking, and communication are necessary to ensure that contact information is kept current. These efforts should improve communication and encourage participation.

The AbilityLinks consortium is addressing the problem of unemployment among people with disabilities. Although many jobs exist in the community that people with disabilities are able to do, employers are just not aware of the untapped resource that exists. At the same time, people with disabilities need a central place to go to find these jobs, which AbilityLinks provides. The assumption guiding this work is that
employment among people with disabilities will increase, if employers consider them good job candidates and they have a central place to look for employment.

Because the consortium is made up of those businesses that are hiring people with disabilities and promoting the hiring of people with disabilities, the larger the membership of the consortium is, the better for the employment of people with disabilities.

The goal of AbilityLinks is to have as many consortium members as possible. Each consortium member means that one more business or community organization has a better understanding of the value of hiring people with disabilities and may give someone with a disability a job in the future or promote employment of people with disabilities in some way. Member benefits include:

- Access to candidates who have equal job performance, low turnover, and low absenteeism, which reduces business costs for recruiting and training
- Access to education, training, and networking events for job seekers and consortium members
- Opportunity for businesses to demonstrate support for equal opportunity to employees, customers, and government agencies
- Free access to post jobs and search résumés on www.abilitylinks.org

Members are recruited through visual and written materials distributed to businesses and other community organizations. The Business Leadership Network in Chicago also specially developed an educational video to be shown at business gatherings. Other business events also have been used to educate businesses about AbilityLinks and recruit for the consortium.

In addition to businesses, the AbilityLinks consortium is made up of nonprofit groups, including those serving people with disabilities. These are essential members of the consortium who get the word out to people with disabilities who might be looking for jobs. The consortium targeted centers for independent living as a way to reach out to disability organizations in the community and expand to a more regional scope when recruiting.

Increase Level of Commitment

As with many coalitions, the AbilityLinks consortium has varying levels of involvement from the 150 entities that form the consortium. An annual strategic planning meeting will help increase the level of commitment from members. Members can be involved in a variety of ways, including education and training events, fundraising, and serving on committees.
Obstacles to participating in the consortium have related mostly to a lack of knowledge and understanding about the employment of people with disabilities. Many employers have incorrect ideas about employing people with disabilities such as thinking they have a high absenteeism rate or require a high cost for accommodation. One of the best ways to remove these myths is through education. AbilityLinks does this at its employer breakfasts, which it also uses to recruit new consortium members.

Over time, the consortium has become a more cooperative effort and has experienced less turf issues related to job placement. AbilityLinks also has gained name recognition and credibility among the business and disability communities, which has helped overcome resistance. Strategic planning meetings are used as a means to foster this cooperation and describe potential barriers or opposition to your partnership’s success and strategies to overcome them.

Turf issues have surfaced as a barrier related to resistance by consortium members to join and become involved. Employment and job placement can be competitive with service providers competing for job placement credits and businesses competing for the best employees. AbilityLinks strives to serve as a neutral party to address turf issues and convince the parties that the cause is worthy.

Study Exercises

1. Describe the types of multiple organizations that have come together in common purpose.
2. The TTM of Stages of Change includes stages from precontemplation to maintenance. The consortium conducted activities to bring partners to the consortium. Identify what activities and what stages of TTM it may have influenced.
3. It is important to understand barriers to reaching goals. Identify and discuss some of largest possible stumbling blocks for this consortium.

BIBLIOGRAPHY


