Running Head: The Community Health Action Model: Health Promotion by the Community

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# Health Promotion by the Community

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Abstract

The goal of the Community Health Action Model is to depict community health promotion processes in a manner that can be implemented by community members to achieve their collectively and collaboratively determined actions and outcomes to sustain or improve the health and well-being of their community, the community as a whole, for the benefit of all. The model is unique, in its ability to merge the community development process with a compatible community assessment, planning, implementation and evaluation framework. Using this model, the community takes ownership, gives direction, and assumes responsibility for its activities and the resulting outcomes. The health professional engages, not from the role of expert, but rather acts as a resource to the community. Through public participation, community members come together, and interact as a collective unit. They express and demonstrate a sense of community, before moving to action to gather information, determine goals, implement plans and evaluate outcomes. The community action model supports community participation leading to community-engaged assessment and change. In this paper, the Community Health Action Model is depicted, its genesis described, and its utility demonstrated.

Key words:

community health, health promotion, community development, participatory action

The Community Health Action Model has evolved through collaboration and consultation among rural community residents, rural organizations and community-focused researchers at the Rural Development Institute of Brandon University. Literature on community development processes (Kulig, 2000; Raphael, Steinmetz, Renwick, Rootman, Brown, Shedev, Phillips, & Smith, 1999) and documentation of community assessment models with quality of life indicators (Anderson & McFarlane, 2004; Federation of Canadian Municipalities, 1999; Hancock, Labonte, & Edwards, 1999) informed the process and are readily available. The Community Health Action Model is unique, however, in its ability to merge the community development process with a compatible community assessment, planning, implementation and evaluation framework. Using this model, the community takes ownership, gives direction, and assumes responsibility for its activities and the resulting outcomes. Through public participation, community members come together, and interact as a collective unit. They express and demonstrate a sense of community, before moving to action to gather information, determine goals, implement plans and evaluate outcomes. This community development process is not linear but may be sequential and is often iterative in nature. The community action model supports community participation leading to community-engaged assessment and change. In this paper, the Community Health Action Model will be depicted, its genesis described, and its utility demonstrated.

## Definitions and Assumptions

Effective application of the Community Health Action Model is based upon an understanding of the central concepts *community development* and *community health promotion* as synonymous. Similar to definitions of community development put forth by Feather (1994) and English (2000), the term community health promotion also may be viewed as a philosophy, a

process, a project and an outcome. As a philosophy community development and, by extrapolation, community health promotion entails the fundamental belief that people can identify and solve their problems. As a process community health promotion supports citizens as they find their power to effect change. As a project or an outcome, community health promotion involves the work of citizens to bring about change in their community.

The health of a community has to do with the way a community functions, the healthiness of the community as a whole. *Community health* is the ability of a community to generate and effectively use assets and resources to support the well being and quality of life of community members and the community as a whole, in the face of challenges and barriers within the context of their environment. Community health involves reciprocal relationships between people and their environment with the goal of sustainability (Ryan-Nicholls & Racher, 2004). Community resiliency is the ability of a community to respond to adversity and, in so doing, reach a higher level of functioning (Kulig, 2000) or extend community capacity.

A *community* can only exist when a group of people, whether defined by geography or affinity, engages in social interaction, builds ties, exhibits awareness of identity as a group, and holds direct access to collective decision making. Participation is an inherent quality of a community and without participation there is no community, only the potential for it (Hancock et al, 1999; Ryan-Nicholls & Racher, 2004). Although a community may be conceptualized from an objective stance as a system, this work emphasizes community from a subjective position recognizing the community's own construction of reality, its values, beliefs, assets, and unique priorities.

Reciprocity and continuous interaction between people and the social, economic and physical environment that comprise their community is essential to bring about change and

promote the health of individuals and the community itself. When community members participate in gathering information about their community they undertake *participatory action research* (PAR). PAR purposely links scientific inquiry with community development and change, blending research with education and political action (Dickson, 2000). PAR fosters community capacity development, social change, democracy, access and social justice (Thurston, Scott, & Vollman, 2004). PAR includes popular knowledge, personal experiences and other non-scientific ways of knowing. The essence of PAR is movement between reflection and action with participants engaged in three learning cycles: 1) education and analysis to determine what is known, and what needs to be learned about the issue, related to causes, contexts, and consequences; 2) investigation to determine what other information is needed, for what purpose and from whom; and 3) action to address the problem, issue or priority, who will do what and what outcome is sought and reached (Dickson).

## The Community Health Action Model

The Community Health Action Model merges a community development process, including participatory action research, with a framework for community assessment and action to achieve community health promotion. The model depicts ‘doing the right things, the right way’. The process is as important as the outcome. In fact, the process is an outcome.

The core of the model, Figure 1, involves *being* or interactions as people come together to form a collective unit, leading to *belonging* or expression by the group of a sense of community, leading to *becoming* or community action by the group. This community action entails the processes of assessing the community, setting goals and planning for change, implementing change, and evaluating both the processes carried out and the outcomes or changes undertaken.

A comprehensive community assessment requires information collection about the people and the social, physical and economic factors that contribute to the health of the community members and the community as a whole. Ten categories comprise the data collection including population; health; social supports; community processes; recreation, heritage, and arts; safety and security; community infrastructure; environment; economics; and education. A community may begin working in one area and move to include others or take on several categories simultaneously, depending upon the goals and priorities of its residents, the resources available, and the proposed timeline. The assessment informs the planning which leads to implementation and evaluation. Results of the evaluation influence future assessment as illustrated by the black feedback loop.

The *becoming* or community action informs future *being* or interactions as a collective unit as expressed by the feedback loop. Stressors may have an impact on the community at any point in time as demonstrated by the jagged arrows. The overall being, belonging, and becoming depend upon the assets and strengths of the community and its members. These assets and strengths vary and change over time as shown by the broken line encompassing the core of the community. The solid line depicts the health and well being of the community which depend upon the synergies derived through the community processes of being, belonging and becoming in combination with its assets and strengths and those of its residents. As a community engages in collective action to manage stressors by using its assets and strengths, health and well-being are enhanced and the community demonstrates resiliency and builds capacity. Community resiliency and community capacity are depicted by the outer broken line which illustrates community growth.

The community process of being, belonging and becoming or community engagement to take action is merged with the community assessment, planning, implementation and evaluation processes of community development. Only when the right things are done in the right way, by the right people (community members who take ownership, set direction and embrace the outcomes of the work) can effective community health promotion occur. This model demonstrates the merging and simultaneous application of these two pivotal elements.

## Genesis of the Model

The Community Health Action Model is the result of a series of focus groups with residents of several rural and towns and villages in southwestern Manitoba, as well as community meetings, inter-community workshops, and community development projects in rural and northern Manitoba between 1999 and 2004. The focus groups and initial workshop defined ‘rural community’ (Ramsey, Annis, & Everitt, 2001), described a ‘healthy rural community’ (Racher, & Everitt, 2004) and generated a framework for community assessment (Racher, Robinson, & Annis, 2002). The initial framework was based on physical, social and economic factors organized into ten categories, with indictors identified for each category. Three communities used the framework in different ways as a tool to initiate or implement community development.

The genesis of the model has been a building of layers over time. Through observation, participation, and critical discussion, the facets and phases of the model evolved. Existing literature offered insight and language to support the process and inspire the resulting model. Four models in particular have contributed to this work including: the Centre for Health Promotion Model for Quality of Life (Renwick & Brown, 1996); the Revised Community

Resiliency Model (Kulig, 2000); the Neuman Systems Model (Neuman, 1995); and the Community as Partner Model (Anderson & McFarlane, 2004). See Table 1.

*Centre for Health Promotion Model for Quality of Life*

At the foundation of the model and illustrated in the central discs are the dynamic phases of *being*, *belonging* and *becoming*. The earlier humanistic-existential use of these three terms recognized the physical, psychological and spiritual needs of the individual (Raphael et al, 1999; Renwick & Brown, 1996). *Being* reflected the physical, social and psychological make up of the individual. *Belonging* demonstrated the fit between the person and her/his physical, social and community environments. *Becoming* referred to practical, leisure and growth activities that an individual carried out to achieve personal goals and aspirations. The focus was the quality of life and health promotion of the individual in relation to her/his community.

*Revised Community Resiliency Model*

In the Community Health Action Model, the concepts of being, belonging and becoming are moved from the level of individual to the level of community and are the foundation for community health promotion. *Being* reflects the development and existence of a collective unit with physical, social, and economic characteristics. Kulig (2000) in her Revised Community Resiliency Model suggested that the first phase is “interactions as a collective unit” (p. 380). She reminded us that only when interaction and participation occur does a community have potential to exist.

In *belonging*, members of the collective unit develop relationships, build trust, generate a common identity and take ownership of that identity. Kulig called this second phase “expression of a sense of community”. This ‘sense of community’ is essential and participation in the collective unit to build a common identity is pivotal to the success of the future work of the

community. The degree of inclusion and the sense of belonging to the collective or community, as experienced by individuals, directly influences their participation, motivation and commitment to the community, the work of the community, and ultimately the health of the community.

*becoming*, the collective group with its sense of community moves to action. Kulig calls this third phase "community action". In the Community Health Action Model, action involves creating common visions, establishing priorities, setting and implementing plans, and evaluating both community processes and community outcomes. Doing the right work, in the right way should lead to improvement in community health. The feedback loop demonstrates the influence of *becoming* or current community action on *being* or future interactions as a collective unit.

*The Neuman Systems Model*

The current state of *being* or health of a community is constantly challenged by, reacted to and altered as a result of environmental forces. Neuman (1995) offered a model of individual health that captures this dynamic interaction. This model has informed our understanding of community behaviour related to community health promotion.

Neuman defined individual health and the current state of being as "the normal line of defense" (p. 30). "Lines of resistance" were activated following invasion of the normal line of defense by environmental stressors. The lines of resistance contained known and unknown internal and external resource factors that supported the individual's health and integrity. Positioned around the normal line of defense or current state of the individual was the "flexible line of defense". This protective buffer ideally prevented stressor invasions and supported the individual's health. The flexible line of defense expanded or contracted depending on the degree of protection available.

In the Community Health Action Model “Community Health and Well-Being” is the goal and hopeful result of effective *community becoming*. “Community Assets and Strengths” are the lines of defense or prevention and the primary resources for community health promotion. They are generated and sustained to manage stressors arising from the physical, social and economic environment. “Stressors” may include community challenges such as unemployment, illiteracy, vandalism or pollution, as well as lack of or threats to services, resources or programs. When a community experiences challenges to its health and well-being, and overcomes those challenges by exhibiting growth such that a new level of functioning is attained, the community demonstrates its resiliency (Kulig, 2000). “Community resiliency and community capacity” provides a dynamic layer of protection to manage future stressors and challenges to community health.

*Community-as-Partner Model*

The work of Neuman (1995) is apparent in the Community-as-Partner Model (Anderson & McFarlane, 2004). Key to this model are the components of the community assessment wheel (p. 195) which include a process for learning about the community by gathering information on the community core, subsystems and perceptions. This model extrapolates lines of resistance and defense from an individual level to the community level. The community core involves history, demographics, ethnicity, values and beliefs; the subsystems include the physical environment, health and social services, economy, transportation and safety, politics and government, communication, education, and recreation; and perceptions encompass those of the residents and the health professional.

The Anderson and McFarlane model is designed to guide the practice of community health nurses, and the community assessment is more about ‘doing for’ than ‘doing with’ the

community. The goal is to formulate “community diagnoses” for “planning in partnership with the community” (Vollman, Anderson, & McFarlane, 2004, p. 265). This model offers useful insight although it stops short of fully embracing a community development or community-engaged and community-driven approach from beginning to end. In keeping with the role of the community health nurse, the focus of this model is situated on the health promotion of individuals and families within the context of the community and less consideration is given to the community as a whole.

The Community-as-Partner Model, however, does offer useful categories or subsystems at the community level for assessment purposes. Rural and northern residents considered these groupings among others (Racher, 2002) as they generated their own experience-related categories for their community assessment and planning framework. Ten categories were generated, initially including: population and demographics; environment; economics; social support networks; community infrastructure; community processes; education; recreation, culture, and leisure; health and social services; and safety and security.

Over time, through ongoing discussions, and application of the model in community settings, participants suggested changes to four categories. Population and demographics became population; health and social services became health; social support networks became social supports; and recreation, culture, and leisure became recreation, heritage and arts.

The model provides a template for community assessment, planning, implementation and evaluation; actions taken by the community for the community, with a goal of enhancing community health. These actions are four key steps of community *becoming.* These steps are iterative, and evaluation informs future assessment phases as indicated by the feedback loop.

The model is situated at the interface of the social, physical, and economic environment of the community. The community processes and outcomes of the community action or *becoming* are evaluated, and this information is used to plan and bring about change in the community or to the community *being*. The evaluation is used to inform future action to promote community health and as the feedback loop indicates, the cycle of community *being*, *belonging* and *becoming* continues.

## Utility of the Model

The goal of this model is to depict community health promotion processes in a user-friendly manner that can be implemented by community residents to achieve their collectively and collaboratively determined processes and outcomes to sustain or improve the health and well-being of their community, the community as a whole, for the benefit of all. The utility of the model lies in its ability to illustrate ‘doing the right things, the right way’ with careful attention to the activities, what is done and how it is done, in relation to the outcomes, what is achieved and how it is achieved. The journey is as important as the destination, and the value of the destination is enhanced by attending to the significance of the journey.

It is widely recognized that when people are involved in projects with full participation, ownership evolves as does commitment to the action and the results of that action. Effective community development or community health promotion requires involvement and participation, across the diversity of the community membership, with all parties empowered to contribute and respected for their contributions. Health professionals and practitioners are not the community experts, but act from roles of community health resource, technical specialist, and knowledgeable steward to the community residents who are the experts in knowing, understanding, and promoting the health of their communities.

In working with members of rural and northern communities, researchers of the Rural Development Institute of Brandon University have developed this model and a resource guide for its use with and by communities (Annis, Racher, & Beattie, 2004). The guide evolves with each iteration as work with communities continues to inform its development. The model and the guide are designed to promote open dialogue, the foundation of partnerships, the bond that sustains relationships, and the mechanism for community action (Racher & Annis, 2005). The model and guide depict the *being*, *belonging*, and *becoming* that is community development as community members come together to interact as a collective unit, express a sense of community, and move to community action; action that is community health promotion.

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Figure 1 Community Health Action Model

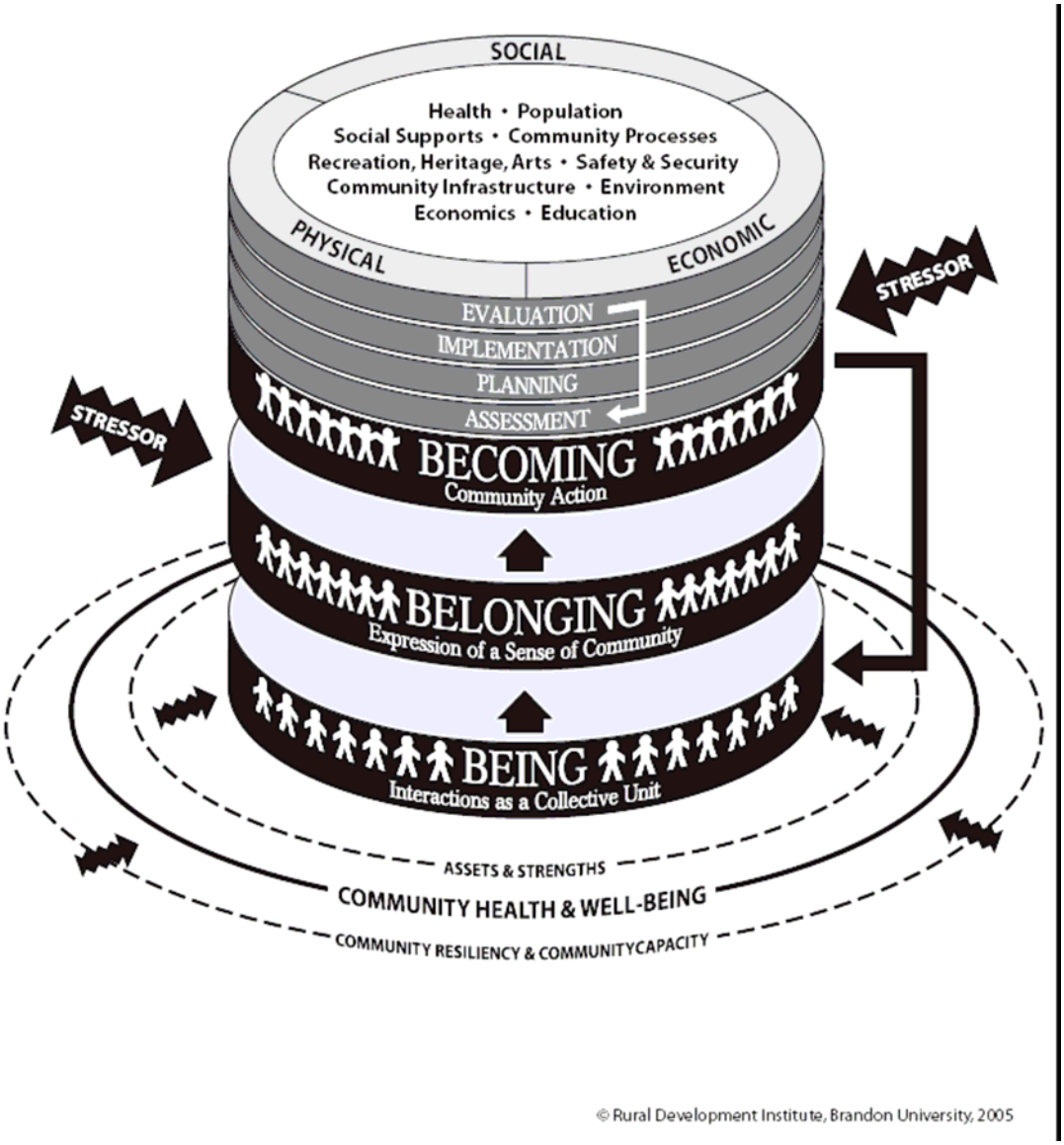

Table 1 Theoretical Contributions to the Community Health Action Model

| | Centre for Health Promotion Model for Quality of Life | Revised Community Resiliency Model | Neuman Systems Model | Community-as-Partner Model | Community Health Action Model |
|---|---|---|---|---|---|
| Goal/Focus | Individual health promotion in the context of community | Community development and resiliency | Individual health | Health promotion of the individual and family in the context of community | Community health promotion of the community as a whole |
| Health and Health Promotion | Individual's quality of life domains:<br>• Physical being<br>• Psychological being<br>• Spiritual being<br>• Physical belonging<br>• Social belonging<br>• Community belonging<br>• Practical becoming<br>• Leisure becoming<br>• Growth becoming | Community resiliency<br>• Interactions as a collective unit<br>• Expression of a sense of community<br>• Community action | Individual level<br>• Lines of resistance<br>• Normal line of defense<br>• Flexible line of defense<br>• Stressors | Community level<br>• Lines of resistance (strengths)<br>• Normal line of defense (health)<br>• Flexible line of defense (buffer zone)<br>• Stressors<br><br>Community assessment wheel with<br>• community core – history, demographics, ethnicity, values, beliefs, history<br>• 8 subsystems | Community health action<br>• Community being - Interactions as a collective unit<br>• Community belonging - Expression of a sense of community<br>• Community becoming - Community action<br><br>Community level<br>• Assets and resources<br>• Community health and well-being<br>• Community resiliency, and community capacity<br>• Stressors<br><br>Community assessment, planning, implementation and evaluation framework<br>• within the social, physical and economic environments<br>• 10 categories |