Community Health and Wellness
Principles of primary health care 6e

The sixth edition of Community Health and Wellness has been fully revised and streamlined to incorporate contemporary thinking and research in community health and wellness from Australia, New Zealand and the global community. The new edition provides an easy-to-use text with a strong focus on the foundational principles of primary health care that underpin community health and wellness. The text builds on the unique socio-ecological approach to primary health care of previous editions, guiding readers to consider the health of individuals and populations in their personal, family and community environments.

Key Features
- Ancillary resources and eBook available on Evolve
- Emphasis on nurses and other health practitioners working in partnership with people and communities
- Focus on primary health care across the lifespan, with an emphasis on health literacy and health promotion
- Local case studies to support the practical application of knowledge to practice
- Additional signposted sources of knowledge online to promote engagement and further enquiry
- Comprehensive coverage on community assessment including a new community assessment framework
- Chapter features include reflective practice and care planning for individuals, families and communities, case studies, interventions and evaluation

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Foreword

This text is based on the foundational principles of primary health care, which guide the reader to consider the health of individuals and populations in their personal, family and community environments. Health professionals engaging with communities use these principles as a basis for implementing a range of strategies to assist people in their journey towards better health. The primary health care mindset recognises that health is socially determined, and the book unpacks the social and structural elements that sometimes enable and at other times compromise health. For the learner, this edition of the text has been streamlined on the premise that evidence for practice is increasingly accessible on the internet and through other electronic means of sharing information. The text therefore provides not only a guided tour through the most important elements of health care knowledge for practice, but also inspires the reader’s appetite for further learning by signposting other sources of knowledge. Together this information can be used to tailor practice strategies to individual ages and stages in the context of community resources and needs. A strength of the text lies in the practice applications of knowledge through case studies, while drawing attention to the fundamental points contained in each chapter, and encouraging the reader to reflect on situations, needs, goals and strategies.

Our trans-Tasman societies are multilayered and the authors outline a broad range of caring approaches that can be adapted for different populations and social geographies. Community health and wellness depends on comprehensive assessment, and this is addressed extensively as the first step in any of these approaches. Moving forward from a base of assessment data relies on understanding features of the health care system as well as government policies, which are constantly changing. These features and policies are presented as a point of departure for planning inclusive, equitable, adequate, culturally appropriate and accessible pathways to health, despite occasional roadblocks. By situating this information in the context of different types of communities and different locations for care, the authors have attempted to instil a sense that health goals can be achieved, and that by working in partnership with nurses and other health professionals, people can be empowered to change unhealthful lifestyles. Another notable feature of the text is its focus on evidence-based practice, including evaluation of current practice. The authors underline the need for all of us to help generate new evidence to fill the gaps in our knowledge. Researching communities is unique; it relies on deep understanding of the dynamics of a community and the cultural conventions that determine how its citizens interact with health care. This is captured in the text to whet the reader’s appetite for what should be a lifelong journey in the evolution of knowledge for practice. I am pleased to recommend this edition of Community Health and Wellness to you with best wishes for your learning enjoyment and scholarly fulfillment.

Emeritus Professor Anne McMurray AM
Preface

This book is intended to guide the way nurses and other health practitioners work with people as they seek to maintain health and wellbeing in the context of living their normal lives, connected to their families, communities and social worlds. Life is lived in a wide range of communities, some defined by socio-cultural factors such as ethnicity or Indigenous status, some defined by geography of ‘place’, others by affiliation or interest, and some by relational networks such as social media. Because most people live within multiple communities it is important to understand how their lives are affected by the combination of circumstances that promote or compromise their health and wellbeing. Knowing a person’s age, stage, family and cultural affiliations, employment, education, health history, and recreational and health preferences has an enormous effect on the way we, as health practitioners, interact with them. Likewise, our guidance and support are heavily influenced by the environments of their lives: the physical, social and virtual environments that contribute to the multilayered aspects of people’s lives. Knowing how, why and where people live, work, play, worship, shop, study, socialise and seek health care, and understanding their needs in these different contexts, underpins our ability to develop strong partnerships with people and communities to work together as full participants, in vibrant, equitable circumstances to achieve and enable community health and wellness.

This edition of the text represents contemporary thinking in community health and wellness from local, trans-Tasman and global communities. We have condensed much of the book from previous editions to reflect the growing accessibility of information online. Access to up-to-date information is available today at the push of a button, so we have therefore focused on the fundamental principles of primary health care that underpin community health and wellness. Using these principles as a foundation, the reader can then use the internet to investigate other, specific areas of interest while maintaining a core understanding of what comprises community health and wellness. We have signposted many areas where readers may want to explore further and we encourage you to also access the supplementary material available online.

Primary health care continues to be an integral approach to promoting health and wellness throughout the world and we apply the principles of primary health care to our practice in this part of the world. These principles are outlined in Chapter 1 and elaborated on throughout the text. A primary health care approach revolves around considering the social determinants of health (SDH) as we work in partnership with individuals, families and communities. The text examines the interrelatedness of the SDH throughout the various chapters, to examine where such things as biological factors, employment, education, family issues and other social factors that influence health and the way we approach our role in health promotion and illness prevention. As partners our role is to act as enablers and facilitators of community health, encouraging community participation in all aspects of community life. Another foundational element that guides our consideration of community health is the notion that health is a socio-ecological construct. As social creatures, we are all influenced by others and by our environments, sometimes with significant health outcomes. The relationship between health and place is therefore crucial to the opportunities people have to create and maintain health. Interactions between people and their environments are also reciprocal; that is, when people interact with their environments, the environments themselves are energised, revitalised and often changed. Analysing these relationships is therefore integral to the process of
assessing community strengths and needs as a basis for health promotion planning. The first two sections of the text focus on the principles and practice of primary health care. A new element of this edition is a section on project planning, equipping the practitioner with the skills to plan projects in and with communities to achieve wellness.

Our knowledge base for helping communities become and stay healthy is based on understanding the structural and social determinants of health that operate in both global and local contexts. We also know that what occurs in early life can set the stage for whether or not a person will become a healthy adult and experience good health during the pathways to ageing. Along a person’s life pathway, it is helpful to know the points of critical development and age-appropriate interventions, particularly in light of intergenerational influences on health and wellbeing. We outline some of these influences and risks in Section 3 of the book, which addresses healthy families, healthy children, adolescents, adults and older people. We provide a set of goals in each chapter for achieving health and wellbeing.

Maintaining an attitude of inclusiveness is the main focus of Section 4. Within the chapters of this section, we suggest approaches that promote cultural safety and inclusiveness in working with Indigenous people and those disadvantaged or discriminated against. To enable capacity development within communities, we need to use knowledge wisely, which means that we need evidence and innovation for all of our activities. Clearly, our professional expertise rests on becoming research literate and developing leadership skills for both personal and community capacities to reach towards greater levels of health, vibrancy and sustainability for the future.

As you read through the chapters you will encounter the Mason family in Australia and the Smiths in New Zealand. Their home lives revolve around their respective communities and the everydayness of busy families. Throughout the chapters you will see how each family deals with their lifestyle challenges and opportunities as they experience child care, adult health issues, and some of the characteristics of their communities that could potentially compromise their health and wellbeing. We hope you enjoy working with them and develop a deeper sense of their family and community development, and how nurses can help enable health and wellness.

Throughout the text, we have included boxes that will encourage you to stop and think on the content (key points and points to ponder) and direct you to find further information ('where to find out more on...'). We have also included group exercises and questions that can be used in practice or tutorial groups to help add depth to your conversations on how to improve community health and wellness.
About the Authors

Jill Clendon is a registered nurse and member of the College of Nurses, Aotearoa. She is currently Acting Chief Nursing Officer at the Ministry of Health in New Zealand. Jill is also an Adjunct Professor in the Graduate School of Nursing and Midwifery at Victoria University, Wellington. Jill spent the 18 years previous to her current position in nursing policy, research, and child and family health. Jill’s research has examined issues with contemporary nursing workforces, the efficacy of community-based nurse-led clinics, and nursing history. Jill has taught at both undergraduate and postgraduate levels with a specific interest in primary health and the contemporary context of community-based well child care in New Zealand. Jill’s qualifications include a PhD in Nursing and a Masters of Philosophy in Nursing from Massey University, and a Bachelor of Arts in Political Studies from Auckland University. She also holds a Diploma in Career Guidance and Certificate of Adult Teaching from the Nelson Marlborough Institute of Technology. She has held a range of community positions including Chairperson of Victory Community Health in Nelson, and as a member of the Nelson Bays Primary Health Care Nurse Advisory Group. Jill has a clinical background in public health nursing and paediatrics.

Ailsa Munns is a registered nurse, registered midwife, and child and adolescent health nurse. Ailsa has practised in a range of hospital and community health settings in metropolitan, rural and remote health settings in Western Australia. She is currently working at the School of Nursing, Midwifery and Paramedicine at Curtin University in Western Australia as a Lecturer, Course Coordinator of the Postgraduate Child and Adolescent Health Nursing Programs and Coordinator of the Community Mothers Program (Western Australia). Ailsa has a range of research interests including exploration of current practice for child health nurses, Aboriginal community-based antenatal care, peer-led home visiting support for Aboriginal and non-Aboriginal families, community nurse-led grief and loss strategies in primary school aged students and prevention of childhood iron deficiency anaemia in rural and remote Aboriginal communities. Her academic qualifications include a PhD in Nursing from Curtin University, Master of Nursing from Edith Cowan University and Bachelor of Applied Science (Nursing) from Curtin University.
Acknowledgements

We offer our appreciation to colleagues, students and friends who supported and encouraged us in the writing of this book; sharing their stimulating ideas, stories and photos have made community health come alive in the hearts and minds of readers. We are grateful to our reviewers who helped strengthen the book, and the team at Elsevier who provided invaluable assistance in producing this work. Bringing a trans-Tasman perspective to the book has been both challenging and rewarding, showing how community health practice underpins health and wellbeing across international communities. Being able to bounce ideas off one another and melding together the various perspectives we bring has been both inspirational and enjoyable. We hope that communities on both sides of the Tasman will benefit from the insights that have come from working together. We would also like to thank and acknowledge our families for their support and patience.

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CHAPTER 5
Assessing the community

INTRODUCTION

This chapter discusses the importance of assessment in the context of primary health care practice. We critique a number of existing assessment tools and introduce a new framework for community assessment based on the social determinants of health (SDH). We also emphasise the importance of working in partnership with the community in the assessment process.

Assessment is the foundation for planning to meet the needs of the community. These needs are identified on the basis of any known risks, hazards and strengths, as well as the priorities and preferences of community residents. To plan effective, efficient, adequate, appropriate and acceptable health interventions we need both scientific data gathered by health planners (top-down information) and community perspectives (bottom-up information). As we mentioned in the first two chapters, an ‘assets’ approach to promoting health focuses on community strengths as well as needs. To generate a list of community assets and needs it is important to create an assessment ‘map’ of geographic, demographic and social information. Geographic data indicate what features or hazards exist in the natural and built environment, the patterns of health and illness among various groups defined by age or gender, and what social conditions require health promotion interventions for community residents. Simultaneously, the assessment involves finding out from members of the community how they assess their health strengths and needs in terms of personal perspectives and experiences. Once this information has been gathered, the next stage of planning is to develop intervention strategies for improvement, or measures that can be taken to sustain positive aspects of community life. The advantage of conducting a comprehensive assessment is that it allows us to forecast patterns of health or potential changes that may have an impact on people's lives or the lives of their children in the future. In the final analysis the information should produce a snapshot of strengths, weaknesses, opportunities and threats to community health.

General knowledge of the community has limited usefulness unless it is analysed in terms of subsequent steps that can be taken in partnership with community members to strengthen community resources and enable health and wellbeing. Selecting an assessment strategy should therefore be goal directed, so that the assessment information is linked to promoting and sustaining community health and wellness.
COMMUNITY ASSESSMENT TOOLS

Community assessment tools have evolved over the years in conjunction with changes in the way we see communities and our ability to promote health. Many decades ago, community assessment was predominantly a checklist approach to assessing communities and their ability to support the needs of residents. A number of tools were developed to ensure that assessments took into account vital information on personal as well as community health hazards and risks. This information was then used to predict people’s exposure to diseases or the risk of accidental ill health from such things as bushfires, drowning or other events common to the area. Many of these tools focused on the population and age-specific risks (asthma in children, for example), with only cursory evaluation of the relationship between health and place, or the assets (e.g. health services) that could help maintain better health. Some of those tools remain useful in assessing community health and the risk of ill health, but in the context of today’s primary health care approach, we recognise that people are quite knowledgeable about their needs and the needs of their communities, and community assessment is incomplete without their input.

One of the earliest approaches to assessment was the epidemiological model, which focused on the determinants and distribution of health and disease. The epidemiological approach was embraced by all health professions on the basis that it reflected a whole-of-population approach and included comprehensive assessment of the person, host and environment, called the ‘epidemiological triad.’ Epidemiological assessments continue to be useful today in developing a base of scientific evidence on health and its determinants in specified populations.

Epidemiological assessment

Epidemiology can be defined as ‘…the study of the distribution of health and diseases in groups of people and the study of the factors that influence this distribution’ (Wassertheil-Smoller & Smoller 2015:83). The classic model of epidemiology is to examine specific aspects of the host (biology), the agent (a causative factor) and environment (factors that exacerbate or moderate the effects of the agent on the host), to see how each of these affects the spread of a disease.
or ill health in the population. The objective of epidemiological researchers is to collect data on the incidence of individuals ‘at risk’ of developing a particular disease in order to inform development of a vaccine or treatment for that disease. Data from epidemiological analyses are presented in terms of incidence and prevalence. Incidence is calculated by dividing the number of new cases in a population by the population at risk, then multiplying this by a base number (1000 or 100 000). This estimates the likelihood that a condition would occur in the population. The prevalence of a certain condition is the number of new and existing cases divided by the population at risk multiplied by 1000 or 100 000 (see Box 5.1).

**KEY POINTS**

**Rate**
A measure of the frequency of a disease or condition, calculated by dividing prevalence by the incidence multiplied by a population base number (1000 or 100 000).

**Incidence**
The number of new cases of a disease or health issue in a specific period of time, divided by the population at risk multiplied by the base number.

**Prevalence**
The total number (new plus existing) of cases of a disease or health issue in a population at any one time, divided by the population at risk multiplied by the base number.
If an occupational group is exposed to a certain toxic substance, a measure of the ‘relative risk’ of becoming ill from that exposure can be calculated by comparing a group (called a cohort) who were exposed to the hazard with a cohort who were not exposed. If the group exposed to the hazard has a higher rate of the illness, that hazard is declared a risk factor. To confirm that it is a risk factor we would then assess its effect over a longer period of time in the entire population, which would provide greater insight. An example of relative risk in relation to adolescent exposure to obesogenic risk factors and depression was outlined in a systematic review conducted by Australian researchers (Hoare et al. 2014). The researchers were interested in understanding if there was an association between obesogenic risk factors (such as physical activity, sedentary behaviour, diet and weight status) and depression in adolescents. They conducted a systematic review of available literature in the five international databases that addressed these issues. Analysis of the eligible studies indicated that although data were typically from non-representative samples, relationships did exist between lack of physical exercise, heightened sedentary behaviour, poor diet quality, obesity or being overweight and depression. In other words, young people who lack physical exercise, have heightened sedentary behaviour, poor diet quality or are obese or overweight, have a greater risk of depression. The authors recommend addressing obesogenic risk as part of interventions to address depression.

**KEY POINT**

Relative risk is a measure of the extent to which a group exposed to a risk has a higher rate of illness than those not exposed, calculated by dividing the incidence rate among those exposed by those not exposed. If the rate is higher among those exposed, it is called a *risk factor*.

The findings from Hoare et al’s (2014) study are important for providing insight into the link between obesity and depression among adolescents, but without analysing individual and group differences, it is difficult to make generalised statements about relative risk and adolescent behaviours. Still, what can we conclude from this review? In some cases, relative risk is not a helpful statistic. The studies cited in the review demonstrated differences in demographic characteristics, ages, stages and ethnicity. Cross-cultural comparisons were limited. Statistical data and statistical comparisons are important tools in health planning, but they must be used with caution in planning whole-of-community interventions.

Because traditional epidemiological measurements of an agent, host and environment are somewhat limited in terms of what we know about the causes of illness, an expanded model, the web of causation, which includes the interconnections between each of these, provides a more comprehensive basis for analysis (see Fig. 5.1). The web of causation is also inclusive of demographic and social features such as age, gender, ethnicity and social circumstances, which is more closely aligned with a socio-ecological model of health and the SDH.
POIN T TO PON DER

If the rate of asthma in preschool children was increasing in a community, how would you go about investigating whether the cause was a risk factor unique to that community, unique to only certain neighbourhoods, or unique to only certain types of families?

Methods that support epidemiology

Contemporary methods to support epidemiological and other community assessment approaches enable information to be quickly and accurately compiled, presenting more quantitatively accurate assessments. For example, geographic information systems (GIS) are being commonly used to plan, administer and analyse community assessment information. GIS can enable identification of a population sample and allow for small geographic area analysis of prevalence data (Pliskie & Wallenfang 2014). The use of GIS is increasingly a requirement in epidemiological analysis and its use in assessing needs at the community level is growing (Pliskie & Wallenfang 2014). However, the risks of the GIS approach mean that some smaller population cohorts within a community may not have their needs identified. For example, the different needs of
Assessing the community

A small pocket of refugee families in a community or a group of families with children who have Down syndrome and are spread across a wider geographical area may not have their particular needs identified. Statistics from the geographic analysis reveal what is typical and what trends exist in the community, rather than what special needs exist for various segments of the population. This aggregated information contributes to the risk of ‘ecological fallacy’; that is, the risk of misunderstanding individual risk in terms of the overall risk to the majority of the population (Loney & Nagelkerke 2014). To gain a more realistic picture of the community, a combination of information should be used concurrently, such as combining GIS and traditional epidemiology. However, GIS can be a useful tool for spatial analysis of communities; for example, in analysing people's patterns of public transportation usage. The United States Environmental Protection Agency’s community-focused exposure and risk screening tool (C-FERST) is a good example of this type of approach, providing easy access to maps, locally specific environmental data, and other information in a user-friendly format (https://www.epa.gov/c-ferst). New Zealand’s Department of Statistics (www.stats.govt.nz) and Australia's Bureau of Statistics (www.abs.gov.au) provide useful local data but have still to develop the complexity of the US tool. But like population trends, none of these tools capture the breadth of variation in human behaviour, which is a limitation of many systematic approaches.

**KEY POINT**

The ecological fallacy is the risk of misunderstanding individual risk in terms of the overall population risk. Some people’s health is determined by unique factors rather than those that are typical of the group or community.

**Challenges of the epidemiological approach**

Epidemiological approaches to community assessment have traditionally struggled to reconcile the scientific approach with the broader contextual factors that impact on people’s lives and contribute to their health status. Some of the challenges include the struggle to integrate epidemiologically or scientifically determined risk factors with behavioural and social strengths or risk factors; or an inability to identify risk factors whose origins lie in the interactions between individuals, or between individuals and their environment. Epidemiological models are also unable to predict the effects of alternative interventions, which are frequently non-Western in origin (for example, acupuncture), because all interventions tend to be assessed on the basis of traditional Western scientific approaches. Epidemiology also struggles to articulate the experiences of those with multiple co-morbidities, tending once again to focus on an individual disease rather than the impact of multiple co-morbidities on a person or group. So, for example, a person who has worked in an occupation with a hazardous exposure to dust (such as in a flour mill), and who also has lived in a bushfire area, may develop pulmonary disease. The pulmonary condition may also predispose him or her to a number of other risks.
As researchers have become aware of epidemiological limitations, many have become committed to analysing community input in a way that would capture people’s experience of certain risks. For example, some epidemiologists have identified that not all people on low incomes experience their life as deprived. This has led them to conclude that using income solely as a determinant of health may not be the most appropriate way to judge needs or risks. In fact, it is more helpful to health promotion planning to understand how people experience deprivation, and the ways deprivation may impinge on their health, than to simply link low income to poor health (Gunasekara et al. 2013). These types of studies provide useful information on population health status contributing to our knowledge of communities and their needs.

**THE EVOLUTION OF COMMUNITY ASSESSMENT TOOLS IN NURSING**

Assessment tools to gather information on community health have evolved over past years to incorporate more appropriate representation of the social characteristics of communities. This refinement of approaches to assessment is useful in prompting nurses and other health practitioners to base health policies and programs on knowledge of the SDH and to include community input. As far back as the 1980s several models of assessment were developed to be used in combination with epidemiological data. West (1984) devised an assessment tool based on the interaction between people and their environments in a small community. The tool included analysis of interactions, actions and awareness, and, although it was comprehensive,

**KEY POINTS**

**Limitations of epidemiology**

- No contextual information
- Human behaviour
- People’s preferences
- Individual experiences
- Social and political factors ignored

(cardiac, renal, stress-related diseases). In this case it would be difficult to pinpoint the cause of ill health to the workplace, the natural environment or the lack of preventative programs that would have provided protection from agents that can cause respiratory problems. The message is that epidemiological data provides only part of the picture. It is also necessary to search for causes of ill health in the social and political factors that impact on health (Chauvel & Leist 2015, Wassertheil-Smoller & Smoller 2015).
it was somewhat diffuse and was not validated with larger communities. Its strength was that it was intended to capture extensive information about how people felt about their community, which was helpful in encouraging the primary health care principle of community participation. Another community assessment tool of the 1980s was developed to correspond to functional health assessment of individuals living in the community (Fritsch Gikow & Kucharski 1987). However, this tool did not reflect a primary health care approach, and instead was focused on structured assessment of community health patterns that corresponded to personal health patterns, such as health perception and management, intersectoral role relationships and social issues. The assessment was very ‘top-down’, and based on health practitioners’ presumptions about health patterns among the population. Some of these patterns may be relevant to particular communities, but the assessment approach implied that we could use a ‘one-size-fits-all’ approach to community assessment. The major limitation of this type of tool is that it is inefficient and ineffective without valuable community input from which planners could predict the relative success of their interventions on the basis of community acceptability. In addition, simply assessing patterns of health and ill health fails to consider inequities between different groups of people, which is important to achieving the primary health care goal of social justice.

**KEY POINT**

Simply assessing patterns of health and ill health fails to consider inequities between different groups of people, which is important to achieving the primary health care goal of social justice.

The assessment tool mentioned above, and other assessment tools of the 1980s, reflected the commitment of nursing to the systematic approach of the nursing process. The nursing process revolves around making nursing diagnoses, typically described as ‘deficits’ that nurses can address. Clark’s (1984) model of assessment is a comprehensive tool specifically aimed at facilitating a nursing diagnosis. It was originally described as the ‘epidemiologic prevention process model’, and has more recently been known as the ‘dimensions model of community health nursing’ because of its later focus on the determinants of health and the dimensions of nursing (Bigbee & Issel 2012:373). Categories of information include general information about the community, epidemiological information such as population characteristics and health status indicators, attitudes towards health, environmental factors and community relationships with society. Box 5.2 provides a case study of the development of Clark’s assessment model over time.

Like Clark’s model, Anderson & McFarlane’s (1988, 2014) assessment tool is based on the nursing process. Their assessment model is based on their philosophy of ‘community as partner’, which is congruent with primary health care, and a ‘systems’ approach to the community. Systems approaches are derived from the notion that a community is a living system that is more than the sum of its parts because of numerous and ongoing internal and external interactions that help maintain homeostasis (Neuman 1982, Neuman & Fawcett 2010). In Anderson & McFarlane’s (2014) adaptation of Neuman’s systems model, assessment is guided by an
assess the community and its health needs. They use a specific tool or model to guide their assessment. This tool has been well-researched and adapted for use in different contexts and countries. The model is useful because it helps nurses identify the health needs of the community, but it is limited by its focus on traditional methods of assessment without involving the community members themselves. This highlights the importance of community engagement in the assessment process.

So what does this tell us?

The development of models help guide nursing practice with communities, and this case study demonstrates how models evolve over time as new knowledge is gained. Being aware of the history of model development helps nurses understand past practice in the context of contemporary practice and encourages us to explore new models and practices based on our previous experiences and knowledge.

What do you see as the next phase in community assessment model development?

(Source: Clark 2003, Clark et al. 2003, Clark 2014)
‘top-down’, deficit approach; that is, the identification of community problems rather than strengths, and seeking community input after problem identification. An existing concern with many community assessment approaches is a lack of community involvement in the early stages of the process. Communities should be involved as early as possible, as we underline throughout the chapter.

**BOX 5.3**

**A COMPARISON OF COMMUNITY ASSESSMENT: ANDERSON AND MCFARLANE, AND CLARK**

- Physical environment
- Economics
- Education
- Safety and transportation
- Health and social services
- Politics and government
- Communication
- Recreation

- Physical
- Biophysical
- Socio-cultural
- Behavioural
- Health system

**POINT TO PONDER**

Early assessment models included person–environment interactions and were not always inclusive of what we now call the SDH. They were also intended to provide a nursing diagnosis as a basis for systematic health planning.

What are the strengths and weaknesses of these early approaches?
Although the early assessment tools were devoid of community input, they did help advance nursing’s scientific agenda, by systematising the processes of assessment. Over time, those using the tools began to recognise the importance of social and interactive factors that are so important to community health. However, by being prescriptive about categories of assessment data, sometimes critical information was overlooked, including the need to assess cultural factors within various community neighbourhoods and groups. Subsequent community assessment models have contributed to a deeper understanding of the cultural domain of assessment, following the lead of Leininger (1967) and other nursing theorists (Tripp-Reimer et al. 1984, Giger & Davidhizar 2002, Ramsden 2002, Jirwe et al. 2006, Leininger & McFarland 2006). Cultural assessment is now a major focus in community assessment, integrating cultural information with other assessment information. Cultural assessment strategies are intended to provide the depth and breadth of locally identified information that is crucial to ensuring their acceptability in the context of the nurse–client relationship.

**KEY POINT**

All cultural assessments must include the perspectives of members of the cultural groups on their assets, strengths and needs.

Cultural assessment information can include community members’ perspectives on their worldview, relevant issues related to ethnicity, values, beliefs, history and social orientation. For refugee and migrant groups, information on pre-movement, migration and post-migration events is also collected to assess the combination of social, environmental, cultural and medical factors that determine health. Despite the often traumatic experiences of refugees prior to resettlement, a strengths-based approach to assessment enables the identification of resilience in the face of adversity, mediating factors that enable or constrain the ability to cope with adversity, and the facilitators that enable positive coping (Edge et al. 2014). Comprehensive assessment of refugee populations, which includes detailed information on family factors, family reactions to the transition to a new country, the impact of changes, and aspects of the host community that cause or exacerbate the trauma and stress of dislocation is essential. An important element of the cultural assessment involves assessing health care providers, as some researchers have found that accessibility and use of services is dependent upon cultural and language competencies of staff members (Tyrrell et al. 2016). Including cultural assessment in all community assessments is congruent with the work of Ramsden (2002) in highlighting cultural safety in all professional interactions. Cultural information also provides a more realistic picture of the community and its socio-cultural environment, and shifts the emphasis from the deficit model of the nursing process to the more positive ‘asset mapping’ model of assessment.
Deficit models of assessment, such as the nursing process, can be helpful in identifying needs and priorities for health service provision; however, in order to provide a comprehensive picture of a community, it is essential to include assessment of positive community features or ‘assets’ (Edge et al. 2014, South et al. 2017). (See Fig. 5.2.) Asset mapping is a more resourceful, inclusive approach that can help identify health inequities in the community, particularly if the assessment includes information on the capability of communities to identify problems and activate solutions. This approach to assessment is therefore responsive to the goals of primary health care and the SDH. An asset map is intended to build an inventory of community strengths in relation to the SDH. Data consists of epidemiological information on the population, their key assets at each stage of life, the physical, environmental and social assets in the community, and the links between these assets and health outcomes (South et al. 2017). This

Figure 5.2 The asset model
SECTION 2 Primary health care in practice

Assessment information can provide a foundation for planning strategies to reduce health inequities. Categories of information include primary building blocks (assets and capacities of residents, their skills, talents and experiences, the presence of community associations under neighbourhood control); secondary building blocks (assets in the community controlled primarily by outsiders, such as physical resources, land, waste, energy, public institutions and services); and potential building blocks (resources outside the community controlled externally, such as public capital and expenditures) (South et al. 2017). From this base of evidence members of the community can work with health practitioners to identify actions to improve health that will be evaluated for their effectiveness. In particular, the use of asset-based community development can help mobilise a community to address identified need using identified assets (Mathie et al. 2017).

However, in using this approach to assessment, consideration must be given to the way data are aggregated. As noted earlier in the chapter, if the information represents an epidemiological approach that focuses only on the total assets within each of these building blocks, it would be difficult to identify pockets of inequity among subgroups, even within a particular neighbourhood. As a guide for planning to meet the goals of primary health care, it would be necessary to ensure that information was stratified, or categorised according to groups such as the homeless, young people, older citizens and those with disabilities. Examples of how this can be achieved are growing. For example, researchers in Boston, USA, used asset mapping to identify a discrepancy between perceptions of community residents with diabetes regarding available assets and the actual assets in the environment. This enabled implementation of targeted health interventions to improve understanding of neighbourhood resources that can help people control their diabetes (Florian et al. 2016).

KEY POINTS

Assets that can be mapped include:

- primary—resident controlled features
- secondary—externally controlled features
- potential—external resources that could be mobilised.

COMMUNITY-BASED PARTICIPATORY RESEARCH (CBPR)

The strength of asset mapping is that it is a community-based approach to assessment intended to respond to the SDH, and it continues to evolve. A related assessment approach is encompassed in community-based participatory research (CBPR), which is designed to equitably involve all partners in the research process—in particular community members—to assess community needs from the perspective of residents (Zittleman et al. 2014). CBPR uses a range of processes...
including focus groups and individual interviews to foster collaborative identification of community needs as a basis for plans to improve health and wellbeing (Zittleman et al. 2014). This type of approach has been shown to be effective in a number of contexts, particularly for occupational and environmental health planning, but increasingly, as a strategy for conducting research with cultural groups (Couzos et al. 2015, Katigbak et al. 2016, Tyrrell et al. 2016). Together, asset mapping and CBPR represent a goal-directed approach to assessment that is particularly useful for program planning. It is important to remember that most programs are aimed at addressing a specific health problem, which is important, but they are usually confined to a particular population group or health issue rather than the whole of the community. The program planning approach is therefore more closely aligned with selective rather than comprehensive primary health care.

KEY POINTS

Selective primary health care is aimed at health programs for certain groups.
Comprehensive primary health care is a whole-of-community approach.

One of the key elements of CBPR as an approach to community research is the engagement of the community at the earliest possible moment in the process. This ensures that community members are involved in identifying the most appropriate approach to data collection, analysis and reporting, they have a say in how the information is interpreted, they are encouraged to share their knowledge and skills with the researchers and can gain increased knowledge and skills in return. This reciprocal process contributes to community and individual improvements in health literacy and reflects the primary health care principle of community participation. Further information on CBPR can be found in Chapter 10.

ASSESSMENT TOOLS SPECIFIC TO HEALTH EDUCATION PLANNING

Among the most specific, goal-directed tools is the PRECEDE-PROCEED tool for health education planning (Green & Kreuter 2005) (see Fig. 5.3). The objective of the tool is to provide a framework for planning and evaluating behaviour change programmes among members of a community or group (Porter 2016). Like the nursing process models, Green and Kreuter’s model revolves around gathering diagnostic information. Firstly, a social diagnosis which includes examining community issues such as crime, population density, education, unemployment and other aspects that are similar to the SDH. Secondly, an epidemiological diagnosis is made. This identifies rates of morbidity, mortality, disability and fertility and is aimed at determining the extent and nature of the determinants of health in the community (Green & Kreuter 2005). Thirdly, a behavioural and environmental diagnosis is undertaken to identify
factors related to actions people might take and how interactions with their physical and social environments might affect these (Green & Kreuter 2005). Included are preventative actions such as safe sexual behaviour, self-care indicators, dietary patterns, and coping skills. The environmental diagnosis includes geographic and economic indicators of community health, as well as how people connect and relate to health services.

Fourthly, an educational and organisational diagnosis is undertaken resulting in identification of Predisposing, Reinforcing and Enabling factors. Predisposing factors include knowledge, attitudes, values and perceptions of community members, making it essential to assess health literacy at this stage. Reinforcing factors include the attitudes and behaviours of others that can affect behaviour and environments for change (Green & Kreuter 2005). Enabling factors are those skills, resources, assets or barriers that may either support or obstruct wanted change. Finally, an administrative and policy diagnosis is undertaken to clarify what strengths and resources are present in the community to enable it to respond to needs. Once complete, such a detailed assessment allows implementation of changes to begin (Green & Kreuter 1991, 2005). The PRECEDE-PROCEED model has been used for many years to make a community...
diagnosis, but like some of the other models, it is limited by the top-down perspective of the health practitioner on what a community needs or prefers. In this respect, it is limited in providing a comprehensive assessment that includes input from community members who feel empowered to participate in charting the course of community health.

SOCIAL EPIDEMIOLOGY, CBPR, PRIMARY HEALTH CARE AND THE SDH

In a comprehensive primary health care context, assessment information should reveal where inequities exist in the community, what levels of disadvantage exist for which groups in the community, what links there are between community attitudes, local and centralised decisions and health outcomes, and a myriad other relationships relevant to the SDH. One approach to collecting this information is to adopt a ‘social epidemiological’ approach. Social epidemiology is a subset of epidemiology that focuses on the social factors that contribute to the distribution of disease (Tuazon 2016). The goal of social epidemiology is to test associations between the socio-ecological aspects of community life and population health outcomes (Tuazon 2016). This approach is closer to the goals of both primary health care and the SDH than the types of assessment outlined above, in that it is aimed at resolving issues of inequity. Used in conjunction with CBPR, social epidemiology yields a depth and breadth of information that can be helpful for planning.

KEY POINT

Social epidemiology is an approach to assessing associations between the socio-ecological aspects of community life and population health outcomes.

A social epidemiological assessment begins with demographic and epidemiological data, mapping the main indicators of community life. Concurrently, a CBPR study can provide information on what people believe community life is like, what could be done to improve the community, what would improve health, how the health department could help, and how the community nurse and other health practitioners can effectively participate in enabling health and wellbeing (Shaha et al. 2015). Next the social epidemiological data will show the balance between resources and demand, strengths and needs. Among the information collected would be indicators of social capital such as indicators of cohesiveness and bonding, health behaviours, illness indicators and community perceptions. Integral to the process is evaluation of the power structures and how they affect certain groups, to provide policy planners with the information to challenge these conditions, including issues of racism, discrimination or other forms of social exclusion (Couzos et al. 2015). Identifying community assets or strengths can help community members develop empowering strategies to gain mastery and control over health decision making—particularly in communities that have experienced social exclusion.
such as LGBTI and other diverse groups. In this way, information can be inspiring, helping people participate fully in their community and expand their ability to negotiate, influence, control and hold accountable the institutions and decision makers that control their lives (South et al. 2017).

STREAMLINING COMMUNITY ASSESSMENT—THE McMURRAY COMMUNITY ASSESSMENT FRAMEWORK

It should be evident from the assessment models described above that most community assessment tools combine epidemiological data with psychological, socio-cultural and environmental indicators, including information about the health system and its use. The most useful tools are those that combine the multidimensional and dynamic nature of community life as well as capturing individual and family strengths and constraints (McMurray 2014).

Community assessment does not need to be a complex process, although the more information that is included in the assessment, the more likely it will be that the interventions will be appropriate and acceptable to the community. Fig. 5.4 shows the McMurray Community Assessment Framework.

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**Figure 5.4** McMurray Community Assessment Framework
Assessment Framework. The framework describes a step-by-step process for undertaking a community assessment. Each step ensures community members are engaged in the process, which ultimately results in community empowerment.

1. **ENGAGE with the community**

   Approach key community members to identify how you can work with their community to undertake a community assessment. Gain their consent to work in and with the community and work with them to identify how they appraise and assess their health strengths and needs along with their perceptions, priorities and understanding of community assessment. Key community members are those who hold positions of respect and/or authority in the community, either through formal or informal leadership. These people may be community elders, local health care providers, teachers, social workers, town council or community board members, and/or others who may provide services in the community. While speaking with some of these people may simply be a formality, speaking with community elders and gaining their consent to work with you in the community is an essential first step to community assessment. Talk to them about what you want to find out, what they want to find out, and let them tell you where to find the information. They will know who to talk to, where to look for information, and what not to do as you undertake your community assessment. This process will also help establish trust between you and the community and keeps everyone ‘in the loop’ as you go about your assessment.

2. **MAP community strengths, resources and risks**

   Mapping is a two-step process (although both steps can occur concurrently). Firstly, talking with community members yields a wide range of information that shows the demographic ‘mix’ in the community—how many people in which population groups may require certain specific services (e.g. older persons, young children); the mix of cultures in the community; what people think about their lives; opinions about environmental strengths that may support healthy lifestyles, or barriers to health. Find out about people’s perceptions, priorities and relationships—these are the relationships that exist between people, and between people and their environment. Once this information is gleaned, the second part of this step involves mapping resources—trying to understand the capacity for supporting health, and the assets and support systems that may be mobilised for certain interventions. The SDH Assessment Circle outlined in Fig. 5.5 comprises part of the McMurray Community Assessment Framework and enables the mapping of these resources. The SDH Assessment Circle gathers information within the 10 categories of the social determinants of health. The circle incorporates all the elements of community assessment, epidemiological data and social epidemiological information in one cohesive place. Appendix A shows the SDH Assessment Circle broken down into separate sections with accompanying questions. These questions will guide you as you undertake your review and many can only be answered by speaking with community members. Further information on sources of assessment information can be found later in the chapter.
3. **ANALYSE the information in collaboration with community members using a strengths, weaknesses, opportunities and threats (SWOT) analysis**

The third step is to analyse the information gathered using a SWOT analysis to identify strengths, weaknesses, opportunities and threats to community health. Included in the SWOT analysis will be a deeper level of analysis of the community that provides information on the SDH. This analysis should be done in collaboration with community members to ensure the...
way you interpret and make sense of the information is aligned with community members’ understanding of the data. This action will help build trust with the community and serve to facilitate the development of the community-led interventions that make up the final step in the process.

**KEY POINTS**

A SWOT analysis identifies:
- Strengths
- Weaknesses
- Opportunities and
- Threats … to health

4. **EMPOWER the community by sharing the findings with community members and working with them to develop intervention strategies for improvement or measures that sustain positive community life**

The final step is where you work with the community to identify, develop and implement interventions to support the needs of the community. Interventions may be as simple as lobbying local government for a new pedestrian crossing or as complex as a multifaceted diabetes prevention program. Engaging with communities throughout the assessment process is key to empowering community members to identify, seek and implement solutions to their own issues and concerns. An example of the importance of community engagement can be found in a study comparing the effectiveness of a community engagement model for disseminating depression care for low-income women with traditional technical assistance. Ngo et al. (2016) found activating community networks to develop community-specific solutions to improve depression services directly resulted in improved mental health quality of life, fewer missed work days, reduced barriers to care and fewer financial difficulties.

**SOURCES OF ASSESSMENT INFORMATION**

For health practitioners who are new to a community, comprehensive assessments can be daunting, and the sources of information a bit confusing. Some information will be available online in government documents. For example, Australian data on morbidity, mortality and age-related conditions are included in the document 'Australia’s Health,' which is updated every two to four years. This can be found at http://www.aihw.gov.au/. Australian Government Census reports and health department reports on a variety of topics are also available online. The New Zealand Ministry of Health has a range of publications that provide background data on the health status of New Zealanders. The New Zealand Health Survey is now a continuous
study and provides the most up-to-date information on population health in New Zealand. Findings are published on the Ministry of Health website: www.health.govt.nz. Statistics New Zealand (www.stats.govt.nz) is also a useful portal for accessing any statistical data on communities and publishes many existing community profiles developed from census data. For the more enthusiastic practitioner, it is also possible to manipulate Excel data tables to find the specific statistics required for a geographic area. The Yellow Pages are another source of community information, as are community business directories. Some of the most useful information for community assessment comes from local surveys that may have been conducted in recent years, or from observations of community life. A search of websites like Google or PubMed, or any of the research databases (see Chapter 10) may also reveal whether there have been any research studies in the community, which may provide additional information.

Most community nurses and other health practitioners have their own strategies for collecting various types of information, depending on whether they are responsible for the whole community, or practising in specific areas, such as general practice, child, school or occupational health, or in a visiting nurse service. In the first instance health practitioners can become familiar with a community by conducting a ‘windscreen survey’, driving around to gain a sense of the community—a big picture of life in that context. Such a survey can yield information about spaces for recreation, transportation and access, child care services, the location of schools, clinics, hospitals and other health services, places of employment, the state of available housing such as whether there are affordable homes, or whether certain sections of the community seem to be in decline. This type of information can also be confirmed by speaking to various community groups or by analysing records of community activities such as immunisation rates, public health indicators and data from other policy documents that indicate activities of the local council or other authorities (fitness programs, elder day care facilities). Community assets, strengths and risks can also be identified by being attentive to people’s visible health behaviours such as observing people out walking, older persons engaging in Tai Chi, and/or parent get-togethers.

**KEY POINT**

A windscreen survey is an effective way of gaining an understanding of the ‘lay of the land’ in a community.

On completion of an SDH assessment, presentation of your work to the community and/or to your colleagues and peers is a useful way of disseminating the information you have gathered. These groups may have useful ideas on where further information can be obtained, how the information can be used, and what the next steps in the process may be. In the context of community placements, discussion of assessment information with community nurses or the teaching staff supervising your placement can also provide locally relevant information for health promotion.
Conclusion

Assessment of the community enables a deeper understanding of strengths, weaknesses, opportunities and threats to community health. The McMurray Community Assessment Framework provides us with a structure to grow our understanding of a community and work alongside community members to identify and develop interventions to empower communities to address their own health and social needs. Chapter 6 builds on our assessment knowledge to help us plan interventions with individuals, families and communities. Before we move on, take some time to consider how the McMurray Community Assessment Framework may help the Mason and Smith families.

CASE STUDY

Assessing community needs for the Mason and Smith families

We now return to the Smith and Mason families to provide an example of some of the information you may collect as part of assessing their communities’ strengths, weaknesses, opportunities and threats to health. There are distinctive differences in the three communities that influence health and wellness for both families. The mining camp where Colin works is sparse and functional, approximately 1000 km from Perth, the capital of Western Australia and the epicentre of the ‘resources boom’. In the area surrounding the mining camp are several small towns, where each community is composed of a mix of long-term residents and newcomers. Many of the townspeople live in caravan parks because of the shortage and high cost of housing. Some are service workers who service the mine and the local population. The physical environment is challenging, with extreme dry, dusty heat during the day and little rainfall.

Maddington is known as a family-friendly but diverse community with many young families, some of them migrants, and older residents. The Smith family has ready access to the train station and the shopping centre, which they can reach by bus from the stop on their street. There is moderate unemployment in the suburb because there are so many opportunities across a range of jobs to work in the mines, and access to the airport is ideal, within 10 km of Maddington. The Smiths’ neighbourhood has a large number of FIFO families, and an informal mining wives’ club that meets regularly at the community centre. There is a shortage of GPs in the area, but several child health clinics, and a school health nurse attends the public school. The day care is staffed by accredited early childhood educators.

Papakura is a low socio-economic community with moderate levels of unemployment and a high multicultural population. The area has a large number of young families, single-parent households and older retired people. There are also a large number of state houses, private rental properties and some home ownership. The community has a local integrated family health centre which offers general practice, pharmacy and physiotherapy services. There is a local Plunket room and a playground near the shops.
Reflecting on the Big Issues

- Community assessment includes mapping strengths, resources, risks and needs with input from members of the community.
- Epidemiological data provide information on the determinants and distribution of risks and diseases in the population, usually defined as incidence and prevalence rates.
- Quantifying rates of health risks and diseases is useful in some ways, but is not inclusive of community perspectives and preferences or the particular needs of subgroups in the population.
- Socio-ecological assessment tools have evolved over the years to reflect an increasing emphasis on the SDH.
- Asset mapping is a tool for assessment that outlines primary, secondary and potential features and resources that can be mobilised for community health.
- Community-based participatory research (CBPR) can be combined with asset mapping to provide a realistic assessment of community health needs.
- Social epidemiological assessment integrates demographic and epidemiological assessment data with information from the community, often in the context of CBPR.
- The McMurray Community Assessment Framework is an ideal way to ensure data are collected on all the social determinants of health in a community.

Reflective Questions: How would I use this knowledge in practice?

1. Using the McMurray Community Assessment Framework, identify the most important priorities for promoting health in the mining community.
2. What information will you use to assess the Maddington community in relation to its strengths, weaknesses, threats and opportunities for socio-ecological support for the Smith family?
3. What strengths, weaknesses, threats and opportunities are readily identifiable in Papakura?
4. What information do you need to glean from Rebecca and Huia on their family and community needs? Compile a list of questions to prompt your assessment interview with both of the women.
5. What gaps in assessment data did you find from your assessment interviews?
6. What extra sources of information did you use to complete the assessments in both communities?
7. From the assessment data of all three communities, what provisional plans would you put in place for health promotion?
8. Group Exercise: Community assessment
9. Working in small groups, brainstorm the various ways you think information about a community can be collected. Save your ideas and as you work through the chapter, see if the ways you have identified are discussed in the text. Use your discussion forum or pinboard if working online.
10 Group exercise: SDH assessment

Working in groups of two to three, undertake a windscreen survey in your local community. Make notes on what you observe. Consider how the notes you have made (the data you collected) fit into the McMurray Community Assessment Framework and where. Make some notes on how useful you found this exercise and what you learned. Share your findings with the wider group.

References


Primary health care in practice


