

Volume 8

Issue 1 *Community Development and Other
Community Applications*

Article 13

January 1990

Community Health and Development: Applying Sociological Concepts to Practice

Peggy Hickman

Follow this and additional works at: <http://digitalcommons.wayne.edu/socprac>

 Part of the [Sociology Commons](#)

Recommended Citation

Hickman, Peggy (1990) "Community Health and Development: Applying Sociological Concepts to Practice," *Sociological Practice*: Vol. 8: Iss. 1, Article 13.

Available at: <http://digitalcommons.wayne.edu/socprac/vol8/iss1/13>

This Article is brought to you for free and open access by the Open Access Journals at DigitalCommons@WayneState. It has been accepted for inclusion in Sociological Practice by an authorized administrator of DigitalCommons@WayneState.

Community Health and Development: Applying Sociological Concepts to Practice

Peggy Hickman

ABSTRACT

Health for all is a priority social goal set by the World Health Organization. In an international agreement, the world community has agreed to address global health needs through primary health care. Key to primary health care is community health development, a social systems approach to health care based on sociological concepts. This article defines community health, discusses primary health care, and examines the application of selected sociological principles to community health development practice.

“Health for all by the Year 2000” was the challenge issued by the World Health Organization (WHO) in 1978. Declaring health to be the most important social goal in the twentieth century, WHO (1978) proceeded to describe a framework for the achievement of global community health. The approach to be used was called primary health care, a community-based, intersectoral approach which places health within the context of community development. Although the desired outcome—a state of complete physical, mental, and social well-being—may seem like an impossible dream, member nations of WHO (including the United States) have signed an agreement titled the Declaration of Alma Ata, pledging to promote global health within the guidelines for primary health care. Although the goal of health for all is still distant, the efforts to implement primary health care are worthy of note. Setting health in a social rather than a medical context, community health developers have applied a variety of sociological concepts and methods to the

pursuit of community well-being. This article will define community health, discuss primary health care as the framework for promoting health, and examine selected sociological concepts used by community health developers.

Community Health

Twaddle and Hessler (1977) referred to community health as a normatively described social label. Norms define what a community accepts as adequate health, how community members feel about health and the lack of health, and what level of functioning is expected by the community. WHO (1978) has defined health as a state of complete physical, mental and social well-being, with wellness being described normatively by each community. Jazairi (1976) observed that a major problem of defining community health in terms of a positive degree of wellness is that community health is a set of interacting and intersecting characteristics, rather than a single observable entity. Blum (1974) identified the health components of the community system as being the physical, social, cultural, political, educational, and economic environment, group behavior, health care services, and hereditary characteristics of community members. Acknowledging the complex nature of community health, Blum included both process and outcome components in defining health as the capacity of an organism (e.g., community) to maintain a balance appropriate to its level of development and social needs, with relative freedom from gross dissatisfaction, discomfort, disease, or disability, and to behave in ways which promote collective survival as well as individual self-fulfillment and enjoyment.

Cottrell's (1976) concept of community competence has formed the basis for several contemporary definitions of community health. Goepfinger and Shuster (1988) defined community health as the process of effective community functioning or problem solving. Goepfinger, Lassiter, and Wilcox (1982) use Cottrell's concepts in defining community health as an outcome measured by the indicators of commitment, self-other awareness and clarity of situational definitions, articulateness, conflict containment and accommodation, effective communication, participation, management of relations with larger society, and machinery for facilitating participant interaction and decision making. Lackey, Burke, and Peterson (1987) combine Cottrell's concepts with those of Kauffman (1959), Sanders (1953), and Warren (1983) to define community health as a sociological and developmental concept possessing the attributes of attitudes and values, capacities, organization, and leadership.

Primary Health Care

Recognizing the importance of community ownership of a normatively defined goal, WHO has set health within the framework of primary health care. Primary health care refers to the provision of essential health services which are

acceptable and accessible to the entire community. Although societal definitions of "essential" health services vary greatly, international health organizations use the term to mean health promotion and disease prevention services such as provision of clean air, safe water, adequate food, maternal and child health care, immunizations, and health education, as well as basic curative services focused on prevailing health problems. The measures for acceptability and accessibility are socio-cultural, economic, political, technological, and geographic in nature. Community participation in planning and implementation of services is emphasized. The World Health Organization further states that community based primary health care must be a part of overall community development and fit within the context of national health policy and system(s).

WHO (1981a) urges each country to establish national health goals. Traditional public health indicators such as infant mortality are combined with social, economic, and political indicators to measure progress toward community health. Although such indicators often are used comparatively to rank the health status of various countries, WHO (1981b) reiterates that the desired outcomes are to be normatively determined within each country. In the United States, a normative approach to defining and measuring health is found in the "Model Standards" concept developed collaboratively by the American Public Health Association, the Association of State and Territorial Health Officials, the National Association of County Health Officials, the United States Conference of Local Health Officers, and the DHHS Centers For Disease Control (Model Standards Project Work Group 1985). Within the Model Standards concept, community-specific objectives for reduction of levels of preventable disease and death were established, and services required to achieve the objectives were designated through a process of community participation and negotiation.

Within the framework of primary health care, WHO (1978) indicated that community health should be promoted through community development. Although the definitions of community development are as varied as the definitions of community health, the Community Development Society, an international organization of community development professionals, has identified six practice guidelines titled "Principles of Good Practice" (Cary, Anderson, Gibson, and Houde, 1989). Good community development practice promotes informed citizen participation in community planning and problem solving, expands community leadership capacity, and avoids actions which might adversely affect disadvantaged segments of a community. Hereafter, the term community health development will be used to denote the promotion of community health within the guidelines and principles of community development. Lackey, et al. (1987) have attempted to operationalize community health development by describing full citizen partnership in a problem solving process which includes assessment of community health needs, analysis and prioritization of problems, and planning, implementing, and evaluating solutions.

Community Health Development: Sociological Practice

To be effective, a community-focused profession must apply sociological concepts to intervention and research. Collaborative planning for the promotion of normatively defined community health through development of a contextually relevant health care system requires an understanding of community norms, values, sentiments, knowledge, beliefs, history, resources, technology, and power structure. To facilitate analysis of community health development as sociological practice, selected concepts will be grouped into two categories for discussion—focus of practice and approaches to practice.

Focus of Practice

The general focus of community health development is social systems. Community health development uses the concept of social systems as an analytical model as well as a practice model. The social systems stance, as noted by Anderson and Carter (1984) and Bertalanffy (1967:93) may be described as “contextual, interactional, transactional, pluralistic, or perspective.” Primary health care, as defined by the World Health Organization (1978) is both contextual and interactional in content and process. The primary health care system must be developed through an interactional process and fit within the context of the community’s social, cultural, political, economic, environmental, and technological realities as a part of total community development.

A social systems model useful to community health development research and practice is “holon,” a term coined by Koestler (1979) and expanded by Anderson and Carter (1984). Holon is used to express the idea that an entity is simultaneously a part and a whole. Each entity or system is made up of parts or subsystems, of which it is the whole or suprasystem. At the same time, the entity or system is a component or subsystem of a larger whole or suprasystem. Anderson and Carter (1984) suggest the designation of a focal system to identify the social system chosen to receive primary attention within the concept of “holon.” Focal systems may include communities, organizations, groups, families, and individuals. When analyzing a social concern such as health, the practitioner or researcher must understand the sociological context of the concern at a variety of system levels and analyze the impact of change in the focal system on the suprasystem and subsystems. The primary focal system of the community health developer is the community.

Classic sociological definitions of community are used extensively in community health development. Articles by Hillery (1955) and Moe (1977), in which the authors discuss the multiple definitions of community, are frequently cited in texts and assigned as required reading for students of community health and development. To provide workable models upon which to base practice, some analysts in community health and development have grouped the multiple

constructs and characteristics identified by sociologists into community typologies (Blum, 1974; Turner, 1982). Although the resulting conceptual models are as varied as their sociological forerunners, the community as a social system remains the focus of community health development practice and research.

Approaches To Practice

Social systems as the focus of practice require a comprehensive approach to community needs assessment. An example of a comprehensive sociological model frequently used in community health development is Connor's (1969) "Social Compass." Connor identifies twelve elements of the community social system and eleven patterns of social relationships within the community. The elements are norms, positions and roles, power, leadership, and influence, social rank, sanctions, history, space relations, resources, technology, knowledge and beliefs, values and sentiments, and goals and felt needs. The patterns of social relationships include family, education, economy, government, religion, recreation, social class, communication networks, health, agriculture, and groups. The patterns of social relationships identified by Connor correspond to the sectors of the community identified by the World Health Organization (1978) as essential partners in the process of community health development for primary health care. Ideally, a community health developer would analyze each of the eleven patterns of social relationships using the twelve elements of the social compass for a comprehensive community health assessment.

Planning and implementation are conceptually based on a variety of theories of social change and organizational behavior. Although modified practice models are being developed, the conceptual basis is the same as described in texts about social change and will not be reiterated in this article. The following example drawn from a practice situation is used to illustrate the application of sociological concepts to community health development within the framework of primary health care.

A community health developer was requested by a rural midwestern county health department to assist in the capacity of consultant with the development of a program to prevent the epidemiologically identified problem of teenage pregnancies. The general approach to practice selected by the community health developer as philosophically keeping within the principles of community development was Rothman's (1974) "locality development" model of community organization practice. Within the locality development model, the community was viewed as an equal partner in the change process.

The focal community in the example under discussion was the entire county. Based on an awareness that the initial needs assessment had been based on health statistics, the community health developer recommended a second assessment focused on determining the characteristics and felt needs of the county as related to

health. Using a combination of participant observation and key informant interviews, the community health developer guided the staff of the county health department through a needs assessment and analysis of the health and welfare pattern of social relationships, using the elements of Connor's (1969) Social Compass. Because of time constraints, the other patterns were addressed in a cursory manner.

Key information from the re-assessment included the following: Spatially the county population was scattered. Public transportation was not available. County demographics indicated a shift from a youthful population to an aging population. Health ranked low on the hierarchy of community values. Resources were allocated accordingly, with resources for the promotion of health and the prevention and treatment of disease being minimal.

Health, itself, was defined in two ways. The majority of the county defined health as being able to work, or, in the case of youth, to attend school. Refusal or inability to work or attend school was viewed as "unhealthy" or deviant behavior. A significant minority within the county defined health and illness in a punitive context, with health being a reward for morally good behavior and illness being a punishment for sin or misbehavior. Within the majority group, early childbearing was an accepted norm. Teenage pregnancy was considered a reality of community life, but not a problem. The norm for the minority group was deferred childbirth, with marriage prior to initiation of sexual activity being valued.

For both groups, the locus of control for personal and community health was generally ascribed to the physician. Community health planning was reactive rather than proactive, with goals being imposed by state and federal health and social service agencies. Major influence over health decisions belonged to the physicians practicing in the county, with the county health officer being gatekeeper for public health issues. Formal power belonged to the county council responsible for approving and funding municipal programs.

Ranking of community health concerns indicated felt needs of general health services for working "medically indigent" families and support services for frail or ill elderly wishing to live at home. The role of the community health developer during the planning process was that of facilitator and skills builder. Outcomes of the community health developer's consultation included the decision to reallocate personnel and financial resources to programs addressing the identified felt needs.

Historically, the health department had attempted to bring about change by attempting to persuade the medical society to take action. In a Lewinian approach to change, the medical society as an entity was identified during reassessment of the power structure as a restraining force, rather than a driving force, in regard to community health promotion. Driving forces included other health and social service organizations and agencies in the county, churches, and the potential recipients of the county health department's services. Staff of the health department used a variety of community organization approaches to mobilize pressure

on the county council to redirect the community's limited health resources into priority felt needs. Evaluation of the resulting programs one year after initiation revealed client satisfaction and utilization of the services and an improvement in the county's morbidity and mortality rates. Ongoing evaluation was planned to determine whether the improvement in health data was a trend or a coincidental statistical fluctuation.

Recommendations

Recommendations arising from this analysis are twofold. First, community health development is strengthened by the application of sociological concepts to practice and research. Although introductory courses in sociology are part of most community health and development curricula, practice trends would indicate the need for inclusion of advanced sociological concepts, models, theories, and methods. Second, WHO's definition of primary health care emphasizes interdisciplinary collaboration. If WHO's goal of "Health for All by the Year 2000" is to be reached, sociologists must continue to be active members of the community health development team.

References

- Anderson, Ralph E., and Irl Carter
1984 *Human Behavior in the Social Environment*. New York: Aldine.
- Bertalanffy, Ludwig von
1967 *Robots, Men and Minds*. New York: George Braziller, Inc.
- Blum, Henrik E.
1974 *Planning for Health: Development and Application of Social Change Theory*. New York: Human Sciences Press.
- Cary, Lee J., Robert C. Anderson, Duane L. Gibson, and Mary Jean Houde
1989 *The First Twenty Years: A History of the Community Development Society, 1969-1989*. Ann Arbor: The Community Development Society.
- Connor, Desmond M.
1969 *Understanding Your Community*. Oakville, Ont: Development Press.
- Cottrell, Leonard
1976 The competent community. Pp. 195-209 in B. Kaplan, ed., *Further Explorations In Social Psychiatry*. New York: Basic Books.
- Goeppinger, Jean, and George III Shuster
1988 Community as client: Using the nursing process to promote health. Pp. 253-74 in M. Stanhope and J. Lancaster, eds., *Community health Nursing: Process and Practice For Promoting Health*. St. Louis: Mosby.
- Goeppinger, Jean, Peggy G. Lassiter, and B. Wilcox
1982 Community health is community competence. *Nursing Outlook* 30(8):464-67.
- Hillery, George, Jr.
1955 Definition of community—areas of agreement. *Rural Sociology* 29:111-23.

- Jazairi, N. T.
1976 *Approaches to the Development of Health Indicators*. Paris: Organization For Economic Cooperation and Development.
- Kauffman, Harold F.
1959 Toward an interactional conception of community. *Social Forces* 38 (October):8-17.
- Koestler, Arthur
1979 *Janus: A Summing Up*. New York: Random House.
- Lackey, Alvin S., Robert Burke, and Mark Peterson
1987 Healthy communities: The goal of community development. *Journal of the Community Development Society* 18(2):1-17.
- Model Standards Project Work Group
1985 *Model Standards: A Guide For Community Prevention Services*. Washington, D.C.: APHA.
- Moe, Edward O.
1977 Nature of today's community. Pp. 117-37 in Adina M. Reinhardt and Mildred O. Quinn, eds., *Current Practice in Family-Centered Community Nursing*. St. Louis: Mosby.
- Rothman, Jack
1974 *Planning and Organizing for Social Change*. New York: Columbia University Press.
- Sanders, Irwin T.
1953 *Making Good Communities Better*. Lexington: The University of Kentucky Press.
- Turner, J. H.
1982 *The Structure of Sociological Theory*. Chicago: Dorsey Press.
- Twaddle, Andrew, and Richard Hessler
1977 *A Sociology of Health*. St. Louis: Mosby.
- Warren, Roland L.
1983 The good community: What would it be? Pp 393-401 in *New Perspectives on the American Community*. Homewood, Ill.: The Dorsey Press. [Reprint from the *Journal of the Community Development Society* 1/1 (Spring 1970):14-23.]
- World Health Organization
1978 Declaration of Alma Ata. In *Primary Health Care: Report of the International Conference on Primary Health Care*. Geneva: WHO.
1981a Global Strategy for Health for All by the Year 2000. Geneva: WHO.
1981b Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000. Geneva: WHO.