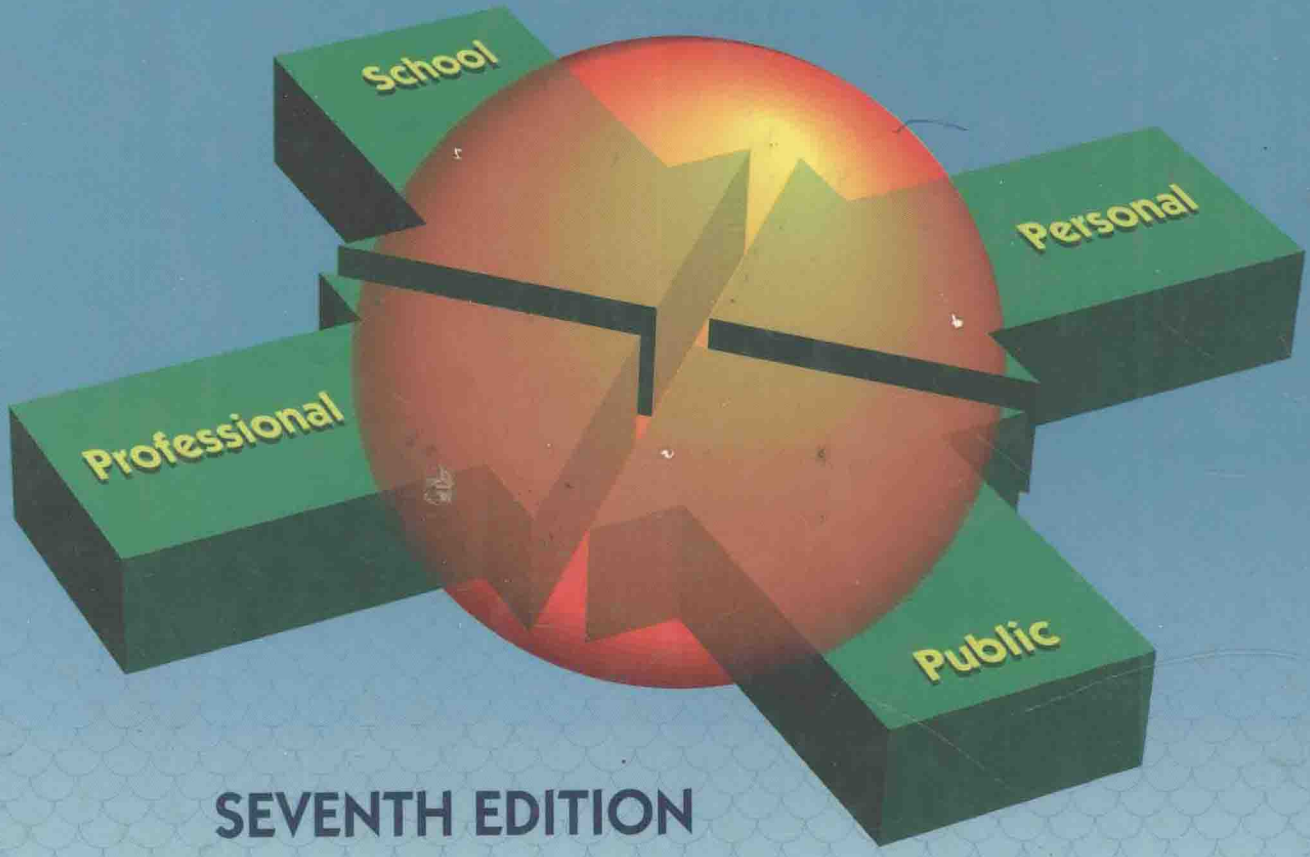
Communi Health

GREEN & OTTOSON



SEVENTH EDITION

COMMUNITY HEALTH

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Coming together is a beginning,
Staying together is progress,
Working together is success,
Laughing together makes it all worthwhile

Preface

Purpose

The seventh edition of *Community Health* remains a general textbook for use in undergraduate and introductory graduate courses in community health. Broader than any single profession or discipline, community health represents the intersection of many disciplines and sectors with public health, school health, occupational health, social and recreational services, and self-care. The book offers a synthesis of the perspectives and content of these spheres of health action.

Recent Developments

The sixth edition appeared in 1990 as a new era in disease prevention and health promotion was under way in several Western nations. Conservative governments were asserting political control in most of these countries, leaving the fate of earlier national health initiatives uncertain. Since then events have vindicated the proponents and architects of disease prevention and health promotion. Their vision was correct, their advice timely, and their plans viable. In Australia, Canada, New Zealand, some European countries, the United Kingdom, and the United States, new governments have endorsed and put their own stamp on disease prevention and health promotion. Some emphasized greater participation of private and voluntary sectors, decentralization, and deregulation. Others emphasized greater equity in the distribution of health resources, greater government responsibility, or greater coverage of preventive and primary care services within medical care plans.

The emphasis on private and voluntary participation has diversified the involvement of agencies, organizations, foundations, and professions in community health matters that were once the exclusive domains of traditional medical and public health agencies. The emphasis on decentralization has shifted health responsibilities from federal to state or provincial and community organizations. The deregulatory thrust of conservative governments put additional pressures on communities to monitor and enforce environmental protections that were previously the province of federal agencies.

Recession and deficit budgets have put pressures on financing traditional medical care and delivery systems. This has produced community innovations in health services and programs. Employers, who have borne a large share of the increased medical costs, have sponsored a myriad of new employee health insurance and health promotion programs with the hope of containing medical care costs.

Chemical and oil spills and the discovery of wastes polluting beaches, water systems, and food

chains have brought the importance of environmental health protection measures more sharply into focus. Lung cancer has now surpassed breast cancer as the leading cause of cancer deaths among women, dramatizing the grim harvest of life-styles developed decades ago and the need to invest now in health promotion to prevent chronic diseases in the future.

Advocacy organizations and community action groups, such as Mothers Against Drunk Driving (MADD) and Action on Smoking and Health (ASH), have made great inroads on local and state ordinances to protect victims of drunk driving and passive smoking in public places. Highway traffic deaths have declined significantly. Dramatic reductions in hypertension and deaths from cardiovascular disease and stroke have demonstrated the effectiveness of community high blood pressure control programs and nutrition, exercise, and antismoking campaigns. In communicable disease control the success of the global eradication of smallpox has been forgotten in the face of the growing threat of acquired immunodeficiency syndrome (AIDS).

The World Health Organization's commitment to a global strategy of "Health for all by the year 2000" has placed renewed emphasis on community involvement in setting objectives and adopting appropriate technologies to meet their own health needs and to develop self-sufficiency in providing their own primary health care. The U.S. *Healthy People 2000* and *Healthy Communities 2000* documents have replaced the 1990 objectives for the nation in disease prevention and health promotion.

These and other late-breaking developments of 1990 through late 1993 are chronicled and examined in this edition in the context of the history and principles of community health.

Basis for Revision

We are very proud that the sixth edition of this text received a Book-of-the-Year award from the *American Journal of Nursing.* Other published reviews and feedback from both users and readers of the sixth edition, interviews with dozens of instructors, and commissioned reviews by five professors representing various college and university programs teaching a community health course all helped with this revision. We have rewritten extensively to make the seventh edition more readable, more manageable within a trimester or semester course, more lively and contemporary, and more helpful. Each chapter includes objectives, boxed issues, summaries, annotated readings, and new and current bibliographies. The end-of-text glossary has been expanded in this edition. Glossary terms are in bold letters where they first appear in the text.

Increased utility. Now class-tested by thousands of students, this text has been repeatedly honed to include the material deemed useful and comprehensible to students. The text responds to student interests and difficulties experienced with the sixth edition. Content that instructors judged least useful has been eliminated. Most of the deletions have been sentences and paragraphs within sections, rather than whole sections. This makes the headings and subheadings more evenly spaced and the text under each subheading more efficiently presented.

Major Features

The book adapts to or anticipates the emerging shape and new content of the field. We have endeavored to reflect community health as it is today, but also to anticipate the directions in which it is heading and should head. Students today are preparing for community leadership in the years ahead. The task of this book is to build a set of concepts and skills for students that will enable them to ask the right questions and to tackle community health problems in the future. The text has undergone a metamorphosis in the last four editions from a primarily descriptive text to an inquiry and problem-solving guide.

Format of the chapters. Besides updated comparative and descriptive data, we have also suggested

how these facts provide a social or epidemiological diagnosis. We then further suggest how the social and epidemiological data on the age group or problem addressed in that chapter can be understood in the context of change or prevention of change. Most chapters offer an inventory of educational, technological, economic, organizational, legal, regulatory, and service measures that can be taken to avert or solve potential health problems. Also indicated are selected objectives appropriate for most communities, based on U.S. national objectives for the year 2000 in disease prevention and health promotion. We have been highly selective in grouping and placing appropriate objectives within the chapters, after eliminating many of the 1990 objectives from the long lists in previous editions.

Part openings. One or two paragraphs at the beginning of each section of the book provide organization and continuity to the chapters in relation to each other. These build on the themes of the book, which cover national policy in community health in both Canada and the United States.

Chapter objectives. A set of objectives at the beginning of each chapter indicates what the reader can expect to learn and to be able to do after completing the chapter.

Case studies and contemporary issues. At least one boxed issue or case study appears in each chapter, bringing the history, organization, and challenges of community health into focus for today's students. Questions are asked in most of the boxed issues to motivate the student to reflect and apply the issue to his or her own community or future.

Photographs and graphs. Most photographs in this edition are new. Line drawings offering conceptual or schematic models are interspersed with the photographs to illustrate the more complex or abstract material. We use some photographs from Third World nations for contrast to build the student's comparative understanding and to illustrate conditions he or she is unlikely to encounter in the more developed world. This is an appeal in part to the inherent interest in the exotic, but it also represents an attempt to broaden perspectives and to emphasize the interdependence of nations for the health of their own citizens and the responsibility of everyone for the health of all. This is the spirit and the essence of community health.

Updated facts and figures. Data presented in this edition have been updated to the 1990s. Delay in publishing official vital statistics by the federal governments of Canada and the United States means that the 1992 or 1993 sources used for each chapter often contained data only through 1990, sometimes through 1991. Unpublished sources were used when permissible to provide the latest data. Most of the specific figures that could not be updated were eliminated for the sake of simplifying the text, making it more readable, and avoiding a cumbersome facts-and-figures memory approach. Epidemiological and vital statistics *concepts* were emphasized rather than *numbers.*

Readability and student interest. In addition to the boxed issues and illustrations, we have inspected every sentence for its utility, clarity, and contemporary tone. Sexist, ageist, or ethnocentric references have been purged. Active verbs rather than passive ones make the reading livelier; complex sentences broken into two or more sentences make the text more straightforward. Rhetorical and review questions and exclamations breathe life into some of the more descriptive material. Transition sentences aid the flow, and additional subheadings make the organization of ideas clearer.

Chapter summaries. At the end of each chapter, a summary highlights the essential concepts and facts and reinforces the objectives of the chapter.

Questions for review. Questions at the end of each chapter elicit application of what has been studied

and encourage dialogue among students and class discussions.

Annotated readings. Selected resources are annotated to enhance the learning process.

Bibliographies. Each chapter provides the most complete and up-to-date resources for further study of the material covered.

Glossary. Important terms are defined in the comprehensive glossary and are printed in boldface type when they first appear in the text.

Appendixes. Three appendixes supplement the content by summarizing areas of community health specialization, common job titles, and graduate degree programs for public and community health accredited by the Council on Education for Public Health.

Supplements. An expanded *Instructor's Manual* and *Test Bank* are available to those who adopt the text. The *Manual* includes 1100 true-false, multiple choice, and matching test questions in the *Test Bank.*

The following elements enhance the *Manual*'s practicality: chapter overviews, additional objectives, student assignments, late-breaking headlines, additional resources, easy test questions, and 22 transparency masters of important illustrations, diagrams, tables, and charts. These transparencies were chosen to help the instructor explain difficult concepts and to illustrate key points.

Acknowledgments

To the students and instructors who classroom tested the previous editions, we express sincere thanks again. We also thank the following reviewers whose contributions are reflected throughout this revision:

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Finally, we wish to thank our family and friends, who have promoted our health along the way. A special thanks to patient Sophe. We are grateful to Cliff, Betty, Harry, and Helga for strong foundations. We hope to have honored those foundations in this book and in our anticipated future with Beth, Doug, and Jenny.

Since completing the previous edition, we have moved from California to the University of British Columbia in Vancouver, British Columbia, Canada. The opportunity here to start a new Institute of Health Promotion Research with an emphasis on evaluation of community health promotion has tested some of the assumptions and concepts written into previous editions. The Adult Education Research Centre in the Department of Administrative, Adult and Higher Education, Faculty of Education, has proved a hospitable home to study health from a community perspective. The importance of engaging adults in their own health and that of their communities reveals itself in the coming chapters. Helping adults move from understanding to acting on health is a shared commitment of the authors. Previous positions put us face-to-face with the many disciplines, professions, and organizations in communities across the United States that seek to develop their community health resources and programs. Now in British Columbia we have an opportunity to develop an understanding of how these issues and responses differ in Canadian communities.

A Visiting Professorship at the University of Limburg in the Netherlands afforded another op-

portunity to work for a concentrated period on the book and to draw comparisons of community health between North America and Europe, as previous editions did between the United States, Australia, Canada, and Singapore. These cross-national comparisons have enriched our understanding of the history, structure, and dynamics of community health. We hope the book reflects this deeper understanding. We are indebted to Professor Gerjo Kok at the University of Limburg for his support of the Visiting Professorship in Maastricht; Professor Rob Sanson-Fisher at the Newcastle University and the Cancer Council of New South Wales for the more recent opportunity to review developments in Australia; UNICEF for an opportunity for both of us to spend two weeks in the People's Republic of China on community health issues; the British Columbia and Canadian Ministries of Health for their support of the Institute, which has made possible our work on this revision; the Center for Substance Abuse Prevention, the BC Health Research Foundation, and the Social Sciences and Humanities Research Council of Canada for opportunities to carry out research on community partnerships, coalitions, and participation in health.

LAWRENCE W. GREEN
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Contents

PART ONE

Foundations

This journey into community health begins with a look at our past and at the foundations on which the structure of community health rests. The foundations are set among our historical roots—not just the happenings of the past but the ideas from primitive to modern that linger in our collective psyche. The essence of the primitive ideas is expressed by the opening quotation from St. Augustine, speaking to us from the fifth century AD, the beginning of the "Dark Ages" of history. The scientific foundations of community health, resting sometimes tenuously among these historical roots, are represented by the four components of the health field concept: *human biology* and *environment* represented in community health by human ecology, demography, and epidemiology; *life-style* and *health care organization* represented in community health by the social and behavioral sciences, including political science, economics, and health education.

Chapter 1

Through the Centuries

All diseases are to be ascribed to demons.
SAINT AUGUSTINE

The history of public health might well be written as a record of successive redefinings of the unacceptable.
SIR GODFREY VICKERS

OBJECTIVES

When you finish this chapter, you should be able to:

- Identify the three essential elements of community health promotion (educational, social, and environmental interventions)
- Describe examples of how they have been reflected in the customs, beliefs, codes, laws, and programs of the major historical eras
- Relate current issues in community health to their historical precedents

Health has been defined by the World Health Organization as a state of complete physical, mental, and social well-being, not the mere absence of disease or infirmity. **Well-being,** especially social well-being, requires for its meaning an understanding of the historical circumstances that have caused a particular population or community to accept some conditions that another community would define as unacceptable. **Community health** reflects the philosophy, religion, economics, form of government, education, science, aspirations, and folklore of any given period. The history of community health chronicles the advances and declines of societies and human conditions. Consider your own community's history over the past few years, with population and industrial growth or decline, with economic improvements or recessions. Consider the health-related headlines in your local newspapers: abortion, acquired immunodeficiency syndrome (AIDS), teenage pregnancy, drug abuse, drunk-driving laws, toxic waste dumps, fitness, the aging population, seat belt legislation, air pollution controls, computer invasions of medical and vital registration records, and control of nuclear wastes.

Such controversies reflect community responses to historical trends in health and attempts to shape the history of health and community development.

Recent collapses of social order in Somalia and the former Yugoslavia illustrate how civilization depends on the quality and distribution of health in the general population. Health in turn depends on human advancement and community development in various spheres. Cast in a historical framework, community health is a result of life-styles as well as a barometer of conditions that shape life-styles, including human relationships.

These observations describe community health, but they risk characterizing it as only a passive consequence of historical circumstances. Community health also represents a dynamic human enterprise that shapes history. People devote their careers and organizations devote their missions to the promotion of community health.

WHAT IS COMMUNITY HEALTH PROMOTION?

C.-E.A. Winslow characterized public health practice as the science and art of preventing disease, prolonging life, and promoting health and well-being through organized community effort for the sanitation of the environment, the control of communicable infections, the organization of medical and nursing services for the early diagnosis and prevention of disease, the education of the individual in personal health, and the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health.

By this definition public health practice overlaps some aspects of medicine, nursing, school health, and personal health, and overlaps most aspects of environmental health, disease prevention, and health promotion. Public health tends to be associated with the work of official governmental health agencies, so the term **community health promotion** has come into increasing use to emphasize the more local, collaborative efforts of various public and private sectors. The spheres of action in community health include aspects of public health practice; school health practice; the professional practices of medical, dental, nursing, and allied health personnel; and the personal health practices of individuals and families. Community health lies in the areas in which these spheres overlap, as shown in Figure 1-1. Additional spheres of action overlap with these and contribute to community health, but usually as a by-product of their primary purposes. Such additional spheres include the worksite, in which employee health promotion, safety, and screening programs address adult health much as school health programs do for children. Likewise, the recreational system and the legal system contribute to community health in performing their primary functions. The coordination and integration of these spheres of action make up the practice of community health promotion.

Community health promotion, as described in this book, *is any combination of educational, social, and environmental actions conducive to the health of a population of a geographically defined area. Educational* interventions may be directed at high-risk individuals, families, or groups, at decision makers, or at whole communities by the mass media, schools, industry, and other organizations. *Social* interventions may take the form of economic, political, legal, and organizational changes, including the organization of health care services designed to support actions conducive to health. *Environmental* supports include the structure and distribution of physical, chemical, and biological resources, facilities, and substances required for people to protect their health. The health behavior of a community includes the actions of the people whose health is in question and the actions of community decision makers, professionals, peers, teachers, employers, parents, and others who may influence health behaviors, resources, or services in the community.