THE INFLUENCE OF RURALITY ON COMMUNITY PARTICIPATION IN A COMMUNITY HEALTH DEVELOPMENT INITIATIVE

By

Nancy E. Findholt

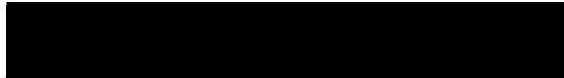
A Dissertation

Presented to
Oregon Health and Science University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

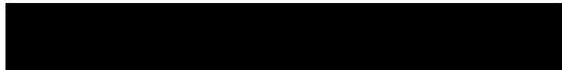
July 27, 2004

APPROVED BY:

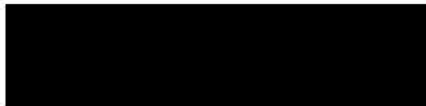
Linda McCauley, PhD, RN, FAAN
Associate Dean for Research, University of Pennsylvania School of Nursing
Research Advisor



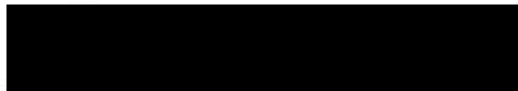
Thomas A. Arcury, PhD
Professor and Research Director, Wake Forest University School of Medicine
Committee Member



M. Jean Shreffler-Grant, PhD, RN
Associate Professor and Campus Director, Montana State University College of Nursing, Missoula Campus
Committee Member



Nancy Glass, PhD, MPH, RN
Assistant Professor, Oregon Health & Science University School of Nursing
Committee Member



Kathleen Potempa, DNSc, RN, FAAN
Vice President & Dean
Oregon Health & Science University
School of Nursing

ACKNOWLEDGEMENT OF FINANCIAL SUPPORT

This project was supported, in part, by grants from the Northwest Health Foundation and from the Center for Research on Occupational and Environmental Toxicology at Oregon Health and Science University.

ACKNOWLEDGEMENTS

This doctoral dissertation could not have been completed without the support of many individuals. I am indebted, first of all, to Linda McCauley, my committee chair, whose adept mentorship contributed immensely to this research. I wish to thank her for her scholarly guidance, her support and kindness, and her confidence in my abilities. The other members of my committee, Tom Arcury, Jean Shreffler-Grant, and Nancy Glass, generously offered their time, expertise, encouragement, and critique during the many stages of this academic undertaking and I am very grateful for this. I was blessed to have a wonderful committee. Each member enriched my dissertation experience.

I am grateful for an excellent graduate education and owe this to the talents of the faculty at the School of Nursing. Special thanks are offered to Bev Hoeffer, whose vision and energy resulted in the Regional Doctoral Program, and to Celia Capuzzi, my initial adviser, who was helpful and friendly to this long-distance student. I also wish to acknowledge my colleagues at the School of Nursing campus in La Grande who cheered me on. I especially wish to recognize Jeanne Bowden, Associate Dean, who did whatever she could to ease my workload during my years of graduate study, and Susan Spangler, whose untimely death sadly means that she will not celebrate with me the completion of my doctoral education.

I also wish to thank Michelle Kegler of Emory University. Michelle shared ideas and graciously commented on my research.

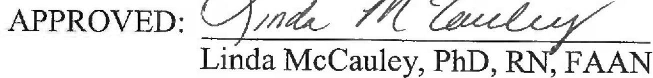
This research required the participation of many people who were involved in the CHIP program in Oregon. I especially wish to acknowledge Paul McGinnis, Community Services Manager with the OHSU Office of Rural Health, whose willingness to share information and help me gain entrée to the rural communities greatly facilitated the conduct of this study. I also wish to express warm appreciation to the CHIP coordinators and team members for their generosity in sharing their time and insights with me.

Finally, I wish to thank my family. My parents, Ray and Bea Warren, always supported my dreams and encouraged me to do my best. My husband, Scott, helped me in ways too numerous to mention. His loving commitment to me is deeply appreciated.

ABSTRACT

TITLE: The Influence of Rurality on Community Participation in a Community Health Development Initiative

AUTHOR: Nancy E. Findholt

APPROVED: 
Linda McCauley, PhD, RN, FAAN

The purpose of this study was to describe how participation in a community health development initiative was enacted in rural communities and to identify factors in the culture and the physical setting and social structure of rural communities that facilitated or hindered community participation. The research design was a multiple-case study featuring three cases of rural communities that were engaged in a community health development initiative. Each community was visited over a three-day period. Data collection methods included semi-structured interviews with key informants from each community's health sector, focus groups with community members from non-health sectors, document review, and community observation. Factors found to facilitate participation included a high level of concern about health services; collective efficacy; a strong sense of community; previous experience and success in social planning; the small size of the community; the involvement of a leader who was unknown to residents; the involvement of newcomers; and a positive perception of the lead organization (i.e., the hospital). Factors that hindered participation included a low level of concern about health services; skepticism concerning collective action; physical, structural, and psychological or interpersonal barriers; and small size of the community (as this pertains to the lack of anonymity afforded to residents). Several community characteristics that had been expected to hinder rural health development were either not present or did not pose a hindrance. The results suggest that community characteristics do have an effect on rural community participation and should be assessed and, if necessary, addressed prior to initiating a health development effort. Recommendations are offered for ensuring broad-based community involvement. The findings are limited by the small size and limited diversity of the sample, the lack of an urban comparison group, the structured nature of the particular health development process that had been followed, and the fact that data were collected at a single point in time. This study provides valuable insight into the characteristics of rural communities and is the first to examine the effect of rurality on community participation in community health development. The study also challenges nurses to renew their commitment to community-based work.

TABLE OF CONTENTS

Approval Sheet ii

Acknowledgement of Financial Support iii

Acknowledgements iv

Abstract v

List of Tables xv

List of Figures xviii

Chapter

I. INTRODUCTION TO THE STUDY 1

Statement of the Problem 1

Purpose of the Study and Specific Aims 4

Significance to Nursing 4

II. BACKGROUND AND CONCEPTUAL FRAMEWORK 6

The Definition of Community Participation 6

The Conceptual Basis for Participation 9

Participation's Role in the Planning and Delivery of Health Programs ..9

Participation's Role in Empowerment 11

Participation's Role in Democracy and Social Justice 14

Factors that Influence Community Participation 16

Who Participates and Who Does Not? 17

Why Do People Participate? 18

What are the Characteristics of Organizations that

Facilitate or Hinder Participation? 20

What Characteristics of Communities

Facilitate or Hinder Participation? 21

Rural Health Beliefs and Practices 23

The Concept of Health 23

Self-reliance 25

Insider *vs.* Outsider 26

Health-Seeking Behavior 27

Summary of the Background for the Study 28

Conceptual Framework 29

Definitions 34

Factors Pertaining to the Rural Culture 34

Factors Pertaining to the Physical and

Social Structure of Communities 34

Assumptions 35

Research Questions and Propositions 36

Summary 47

III. METHODOLOGY 48

Research Design 48

Sample and Setting 49

Sampling 49

Case Selection 50

Data Collection 52

Preparatory Activities 52

Case Study Protocol 55

Data Collection Methods 55

Key Informant Interviews 56

Focus Group Interviews 58

Document Review 59

Community Observation 61

Description of Interview Questions 61

Priority Given to Health 62

Perceived Efficacy of Collective Action 63

Insider *vs.* Outsider Differentiation 63

Sense of Community and Commitment to Community 63

Physical and Structural Barriers 63

Civic Organization and Experience with Social Planning 64

Leadership 64

Resources 65

Human Subjects Considerations 65

Data Management 66

Data Analysis 66

Data Reduction 67

Data Display 69

Conclusion-drawing and Verification 73

Establishing Trustworthiness 75

Confirmability 75

Dependability 76

Credibility 76

Transferability 78

IV. DESCRIPTION OF THE COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP 79

V. CASE DESCRIPTION OF COMMUNITY A 84

Community A Description 84

How Participation Was Enacted 86

What Kind of Participation? 87

Who Participated? 92

How Did Participation Occur? 93

The Influence of Cultural Characteristics on Participation 99

Priority Given to Health 99

Perceived Efficacy of Collective Action 103

Insider *vs.* Outsider Differentiation 106

Sense of Community and Commitment to Community 109

Summary 112

The Influence of Physical Factors and Social Structure on Participation 117

Physical and Structural Barriers 117

Civic Organization and Experience with Social Planning....................118

Leadership....................121

Resources....................123

Summary....................124

Additional Findings....................128

Positive Perception of the Hospital....................128

Small Size....................128

The Presence of Newcomers....................130

Perception of Being Disenfranchised....................132

Avoidance of Competition and Conflict....................133

Summary....................134

VI. CASE DESCRIPTION OF COMMUNITY B....................137

Community B Description....................137

How Participation Was Enacted....................139

What Kind of Participation?....................140

Who Participated?....................145

How Did Participation Occur?....................147

Cultural Characteristics and Their Influence on Participation....................153

Priority Given to Health....................153

Perceived Efficacy of Collective Action....................154

Insider vs. Outsider Differentiation....................157

Sense of Community and Commitment to Community....................159

Summary....................162

The Influence of Physical Factors and

Social Structure on Participation 166

Physical and Structural Barriers...166

Civic Organization and Experience with Social Planning...................167

Leadership...169

Resources 172

Summary 173

Additional Findings 176

Poor Perception of the Hospital 176

Limited Communication 177

Isolation...177

Summary 177

VII. CASE DESCRIPTION OF COMMUNITY C 179

Community C Description 179

How Participation Was Enacted 181

What Kind of Participation? 182

Who Participated?...187

How Did Participation Occur?..189

Cultural Characteristics and Their Influence on Participation.................193

Priority Given to Health..193

Perceived Efficacy of Collective Action..194

Insider *vs.* Outsider Differentiation 197

Sense of Community and Commitment to Community.......................200

Summary 202

The Influence of Physical Factors

and Social Structure on Participation 206

Physical and Structural Barriers 206

Civic Organization and Experience with Social Planning 207

Leadership 209

Resources 214

Summary 215

Additional Findings 219

Small Size 219

The Presence of Newcomers 219

Change in Hospital Management 221

Recent Funding Cuts 222

Summary 224

VIII. CROSS-CASE COMPARISONS 226

Comparison of the Communities 226

How Participation Was Enacted 228

Similarities in Participation That Were

Due to the Structure of CHIP 231

Similarities in Participation That Were Not

Due to the Structure of CHIP 233

Differences in How Participation Was

Enacted Across Communities 234

Cross-Case Comparisons on Factors from the Conceptual Model 239

Priority Given to Health 239

Perceived Efficacy of Collective Action 241

Insider *vs.* Outsider Differentiation 243

Sense of Community and Commitment to Community 245

Physical and Structural Barriers 246

Civic Organization and Experience with Social Planning 247

Leadership 249

Resources 251

Cross-Case Comparisons on Factors Outside the Conceptual Model 252

Small Size 252

The Presence of Newcomers 253

The Perception of the Hospital 254

Summary 255

IX. DISCUSSION, SUMMARY, AND IMPLICATIONS 260

Discussion of Findings 260

How Participation Was Enacted 260

The Influence of Cultural Factors on Participation 262

The Influence of Physical Setting

And Social Structure on Participation 269

Additional Findings 274

Strengths and Limitations of the Study 277

Implications for Practice 280

Recommendations for Policy....283

Recommendations for Future Research....284

A Challenge to Nurses....286

Summary....287

List of References....288

APPENDIX A.... 305

APPENDIX B....309

APPENDIX C....316

APPENDIX D....327

APPENDIX E....330

APPENDIX F....335

LIST OF TABLES

Table Page

1. City and County Population Size and Urban Influence of Communities Selected as Cases for this Study 52
2. Study Factors by Data Collection Method 56
3. Data Derived from Documents by Source and Purpose 60
4. Checklist Matrix: Dimensions of Community Participation in CHIP 70
5. Checklist Matrix: Factors Influencing Community Participation in CHIP 71
6. Conceptual Matrix: Rural Characteristics and Dimensions of Participation 72
7. Selected Demographic Characteristics of Community A as Compared to Oregon 85
8. Dimensions of Community Participation in CHIP in Community A 86
9. Constituencies Represented by CHIP Team Members in Community A 92
10. Description of Cultural Characteristics in Community A 113
11. Cultural Factors Influencing Participation in CHIP in Community A 114

12. Description of Factors Pertaining to Physical Setting and Social Structure in Community A 125

13. Physical and Structural Factors Influencing Participation in CHIP in Community A 126

14. Factors Outside of the Conceptual Model That Influenced Participation in Community A 135

15. Selected Demographic Characteristics of Community B as Compared to Oregon 138

16. Dimensions of Community Participation in CHIP in Community B 139

17. Constituencies Represented by CHIP Team Members in Community B 146

18. Description of Cultural Characteristics in Community B 163

19. Cultural Factors Influencing Participation in CHIP in Community B 164

20. Description of Factors Pertaining to Physical Setting and Social Structure in Community B 174

21. Physical and Structural Factors Influencing Participation in CHIP in Community B 175

22. Factors Outside of the Conceptual Model That Influenced Participation in Community B 178

23. Selected Demographic Characteristics of Community C as Compared to Oregon 180

24. Dimensions of Community Participation in CHIP in Community C 181

25. Constituencies Represented by CHIP Team Members in Community C 188

26. Description of Cultural Characteristics in Community C 203

27. Cultural Factors Influencing Participation in CHIP in Community C 204

28. Description of Factors Pertaining to Physical Setting and Social Structure in Community C 216

29. Physical and Structural Factors Influencing Participation in CHIP in Community C 217

30. Factors Outside of the Conceptual Model That Influenced Participation in Community C 225

31. Comparison of Communities on Selected Characteristics 227

32. Similarities and Differences in How Participation was Enacted Across Communities 229

33. The Influence of Community Characteristics on Participation in CHIP 256

LIST OF FIGURES

Figure Page

1. Conceptual Factors Influencing Rural Community Participation in a Health Development Initiative....................................33

CHAPTER I

INTRODUCTION TO THE STUDY

Go to the people.

Start with what they know.

Build on what they have.

(Old Chinese proverb)

Statement of the Problem

Approximately one quarter of the U.S. population resides in rural areas and research suggests that rural dwellers are in poorer health than their urban and suburban counterparts. Death rates for working-age adults in the most rural areas are higher than for suburban residents, and the highest death rates nationwide for children and young adults are in the most rural counties (Eberhardt et al., 2001). Rural populations have higher rates of chronic illness and infant mortality (Eberhardt et al., 2001; National Institute of Nursing Research, 1995; Rural Information Center Health Service, 2001; Summer, 1991). Death rates from unintentional injuries and motor vehicle accidents are significantly greater for rural residents than for persons living in more urbanized areas (Eberhardt et al., 2001; National Institute of Nursing Research, 1995; Summer, 1991). Rural populations have higher rates of teen pregnancy, smoking and heavy drinking

among adults, and suicide (Eberhardt et al., 2001; National Institute of Nursing Research, 1995). And rural elders report poorer health and a greater number of functional limitations than elders living in urban areas (National Institute of Nursing Research, 1995; Summer, 1991).

Many of the health problems experienced by people living in rural communities are directly related to social, physical, and economic conditions. Rural residents may be predisposed to poor health because rural communities have higher rates of poverty, lower levels of education, and a greater percentage of hazardous occupations (National Institute of Nursing Research, 1995; Rural Information Center Health Service, 2001; Ricketts, Johnson-Webb, & Randolph, 1999; USDA, 1997; USDA, 1999). Distance, not being able to take time off from work, lack of reliable transportation, and lack of health insurance pose barriers for rural families trying to access health care services (Rural Information Center Health Service, 2001; Schur & Franco, 1999; Spencer & Morgan, 2001). In addition, rural residents have a limited number and variety of health care resources available to them. The low population base, high poverty, and geographic isolation make provision of health care unprofitable, and limited technological and professional support have contributed to a severe shortage of health care professionals (Eberhardt et al., 2001; American Nurses Association, 1996; National Institute of Nursing Research, 1995; Rosenblatt & Hart, 1999; Weinert & Burman, 1996).

The values and beliefs that are shared by many rural people also have an impact on their health. Rural dwellers have been noted to associate health with the ability to work, and to place a high value on independence and self-reliance (Weinert & Burman,

1994). In addition, rural residents may be more likely to use informal sources of help and to resist assistance from persons perceived as outsiders (Lassiter, 1992; Weinert & Long, 1990). These characteristics can lead to refusals or delays in seeking health care and reluctance to comply with health providers' advice. Furthermore, the decreased anonymity, which is part of the rural experience, can make it difficult for rural residents to seek help, especially for health concerns that carry a social stigma (Weinert & Long, 1990).

Community participation in health planning and development offers the potential to improve health in communities that are poor, at high risk, and medically underserved. A considerable body of research suggests that long-term public health benefits can be achieved when people work together to create change. As the next chapter will explain, these health benefits may be the result of empowerment that develops at the individual, organizational, and community levels as people participate in health planning. Or the improvements in health may occur because health care programs are often strengthened when community members have a voice in how the programs are designed and implemented. For this reason, many private and public funding agencies require community participation as a condition of support (Lasker, Weiss, & Miller, 2001).

Although there is widespread interest in and support for community participation, those who have tried to implement it have found that participation is complex and difficult to accomplish. In attempting to understand it better, researchers have studied the characteristics of people who participate and those that do not, the reasons people choose to participate, and the characteristics of organizations that facilitate or inhibit

participation (Wandersman & Florin, 2000). Very few researchers have examined how characteristics of communities affect participation. Knowing how a rural community's structure and culture influence community participation is important if effective partnerships are to be established with community members.

Purpose of the Study and Specific Aims

The purpose of this study was to describe the influence of rurality on community participation in a community health development initiative. The specific aims of this research were (a) to examine how participation has been enacted in rural communities; (b) to identify factors within the culture of rural communities that hinder or facilitate participation in community health development; and (c) to identify factors in the physical setting or social structure of rural communities that may hinder or facilitate participation in community health development.

Significance to Nursing

For nurses who have an interest in improving the health of rural populations, there is both a theoretical and a practical reason for learning more about the process of community participation, what barriers serve as impediments to participation in rural communities, and what conditions or actions may facilitate participation. If we accept that the health of individuals and families is largely determined by the health of the community, and that healthier communities are those that have the ability to manage their own health, then understanding how to work with a community in a manner that facilitates involvement and promotes competence becomes critical. Furthermore, from a practical standpoint, successfully engaging a rural community in health planning can lead

to greater acceptance and effectiveness of the resulting health interventions, which, in turn, can lead to improvements in individual and community health.

CHAPTER II

BACKGROUND AND CONCEPTUAL FRAMEWORK

Chapter II develops the background and conceptual framework for this study on rural community participation. Background supporting this inquiry is provided through a discussion of the definition of community participation and the conceptual basis for participation. The research on factors that influence community participation and on rural health beliefs and practices is reviewed to inform the selection of variables to study. Finally, the conceptual framework that guided and organized this investigation is described, and the definitions, assumptions, research questions, and propositions are presented.

The Definition of Community Participation

Although much has been written about community participation, the concept still lacks specificity. The reason for this is that both "community" and "participation" have a wide range of meanings (Robertson & Minkler, 1994; Woelk, 1992).

The word "community" has been used to describe a defined location and the people who live there. It has also been used to refer to a group of people who share certain traits, such as ethnicity or culture, or who experience similar health risks. The fact that people have common characteristics does not, however, mean that they experience a sense of community. Even people who live close together may have very different interests and needs, and might not feel connected.

One definition that takes into account the sense of community is that developed by Israel, Checkoway, Schulz, & Zimmerman (1994). According to their definition, a community is a locale that is characterized by the following elements: (a) a sense of identity and belonging, (b) common symbol systems – language, ceremonies, (c) shared values and norms, (d) mutual influence – community members have influence and are influenced by each other, (e) shared needs and commitment to meeting them, and (f) shared emotional connection – common history, experiences, and mutual support.

The connectedness of a community and the extent to which members share interests and needs is important to participation for two reasons. First, community participation in health development involves collective decision-making and control, and this is not possible unless community members share at least some sense of community (Israel et al., 1994). Second, participatory approaches will only be effective if the interests and needs of all sectors of the community are represented. When communities are not homogenous, which is often the case, special efforts will need to be taken to ensure that the perspectives of all groups, particularly the marginalized, are represented (Meleis, 1992; Woelk, 1992).

The term "participation" also has a range of meanings because of the many levels or forms of participation that can occur. Arnstein (1971) depicted participation as a ladder representing a progression of citizen power over program decisions and resources. At the bottom rungs of the ladder are projects where community members participate only as recipients of services or education. Projects that solicit input from community members but do not allow them to have control over decisions are located in the middle

of the ladder. The highest level of participation occurs at the top rungs where citizens have managerial power and control over decisions and resources. Similarly, Rifkin (1986) visualized participation as an inverted triangle ranging from "benefits", at the narrow bottom point (where people participate simply as beneficiaries of a project), to "planning" at the top (the broadest form of participation, where the community controls the planning process and determines what programs to implement).

In a review of participation in health projects, a WHO Study Group (1991) found that participation had been interpreted in three different ways: as contribution, as organization, and as empowerment. Participation as contribution occurs when citizens participate in predetermined programs by donating resources such as labor, cash, or material goods. Participation as organization involves the development of structures to facilitate participation. Empowering participation involves communities, especially the poor and marginalized, developing the power to make decisions and to have control over health care services.

It is the highest or broadest level–the empowering form–of participation that has been incorporated as a key component of the World Health Organization (WHO) Health For All strategy (World Health Organization, 1978; World Health Organization, 1995). Rifkin, Muller, and Bichmann (1988), taking the WHO intention into account, defined community participation as "a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs" (p. 933). Three characteristics of participation that appear in this definition are activeness, choice, and the possibility of

choice being effective. For the purposes of this dissertation, this definition of community participation was used.

The Conceptual Basis for Participation

Community participation is widely accepted as an essential aspect of public health development for three reasons. First, participation is thought to improve health planning and to enhance the effectiveness of health programs. Second, participation has the potential to empower individuals and communities, and research shows that empowerment is linked to health. Third, participation is morally consistent with the principles of social justice and democracy. This section will explore the role that participation plays in each of these areas.

Participation's Role in the Planning and Delivery of Health Programs

The participation of community members in health planning appears to offer several advantages over conventional planning, where professionals control health care decision-making and problem-solving. Many of the health problems that confront communities today are grounded in socioeconomic and political conditions that are too complex to be resolved by any one person, organization, or sector working alone (Annett & Nickson, 1991; Lasker, Weiss, & Miller, 2001). The insights of local people, who know in a firsthand way about the problems they experience, are invaluable in developing a thorough understanding of these conditions and in designing interventions that will be effective in addressing them (Lassiter, 1992).

When community members are involved in health planning and decision-making, health programs have a better chance of success. Community needs will be more

accurately assessed because people know themselves and their circumstances better than professionals (Jewkes & Murcott, 1998; Lassiter, 1992). Furthermore, involving the community in health planning results in projects that are focused on the health concerns of the community, rather than the concerns of health professionals (Annett & Nickson, 1991; Arcury, Austin, Quandt, & Saavedra, 1999; Kreuter, Lezin, & Young, 2000). Thus, the planning process and the resulting programs gain credibility within the community.

Community participation is also an important factor in developing health programs that are culturally appropriate. If services are to be effective, they must be designed and delivered in a manner that is congruent with community norms and values. Cultural insensitivity is a primary reason for the mis-use or under-use of health services (Annett & Nickson, 1991). Community members know what health interventions are suitable to local lifestyles and norms, and what interventions would be inappropriate or offensive. Therefore, their involvement in planning increases the likelihood that programs will be accepted (Annett & Nickson, 1991; Arcury et al., 1999; Jewkes & Murcott, 1998; Lassiter, 1992). Greater acceptance can translate into higher utilization of health services, which is beneficial to both the community and the program.

The preceding paragraphs document how the knowledge and insights that community members contribute to the planning process enhance the effectiveness of interventions. However, the knowledge that local people *receive* by participating in health planning also aids in health program success. A fundamental principle of health education is that change cannot occur until people recognize the need to change (Minkler

& Wallerstein, 1997). Old attitudes and practices must be reconsidered before change can take place. Involvement of a community in its own health development leads to new awareness and attitudes concerning the health and the causes of ill health, thus making it more likely that change will be successful and permanent (Minkler & Wallerstein, 1997; Rifkin, 1986; Thompson & Kinne, 1999).

Because participation garners community support and acceptance, it has the potential to mobilize significant community resources and energy that can facilitate project implementation (Annett & Nickson, 1991; Bracht & Tsouros, 1990; Kreuter, Lezin, & Young, 2000; Rifkin, 1990). Voluntary contributions of money, materials, and labor are important in extending scarce resources and can make it possible for programs to reach hard-to-reach, at-risk populations such as the poor, ethnic minorities, and persons living in geographically isolated rural regions (Goeppinger, 1993; Rifkin, 1990).

Finally, participation develops local ownership, the sense of responsibility for and control over the health program. When the community perceives that the health program belongs to them, they are more willing to maintain it even after outside sources of support are withdrawn. Hence, participation enhances continuity of services and contributes to project sustainability (Annett & Nickson, 1991; Arcury et al., 1999; Bracht & Tsouros, 1990; Thompson & Kinne, 1999).

Participation's Role in Empowerment

Community participation is also important because it is empowering, and research from several disciplines has documented that empowerment promotes health. Empowerment is a multi-level construct, occurring at individual, organizational, and

community levels. These levels of empowerment are mutually interdependent; empowerment at one level is both a cause and a consequence of empowerment at the other levels (CDC/ATSDR, 1997; Israel et al., 1994; Zimmerman, 2000). Participation is an essential aspect of empowerment. It is interwoven with empowerment at all levels and is both an effective empowerment strategy as well as an outcome of empowerment (Robertson & Minkler, 1994).

Empowerment at the individual level is often referred to as psychological empowerment. It includes three dimensions: (a) intrapersonal – a belief in one's perceived efficacy, competence, and control; (b) interactional – the knowledge and skills needed to understand and influence systems; and (c) behavioral – taking actions to exert control over one's environment (CDC/ATSDR, 1997; Speer, Jackson, & Peterson, 2001; Zimmerman, 2000). The concept of psychological empowerment is linked to participation in that it is through participation in community organizations that individuals develop analytic skills, a critical awareness of their environment, and greater perceived competence and control (Wallerstein, 1992; Zimmerman, 2000).

At the organizational level, a distinction is made between empowering organizations and empowered organizations. An empowering organization provides individuals with opportunities to participate in decision-making, thus enabling them to develop competencies and to increase control over their lives. An empowered organization is one that influences the larger system of which it is a part (CDC/ATSDR, 1997; Schulz, Israel, Zimmerman, & Checkoway, 1995; Zimmerman, 2000). An empowered community is one where citizens and organizations work together to address

community needs. Characteristics of an empowered community include pluralistic leadership, accessible resources for all community members, a variety of voluntary organizations (i.e., coalitions), and equal opportunities for involvement (Zimmerman, 2000). Through participation in collective activities, individuals and organizations provide support for each other, develop problem-solving skills, and gain increased control over the quality of life in their community (Israel et al., 1994). In addition, like an empowered organization, an empowered community has the ability to effect change in the larger social system (Israel et al., 1994).

It is now widely accepted that empowerment is health-enhancing. On an individual level, literature on social psychology and social support has provided evidence that control is an important factor in health. The perception of having control over one's life has been associated with better health habits, compliance, and improved physical and mental health (Heaney & Israel, 1997; Schwab & Syme, 1997; Wallerstein & Bernstein, 1988; Wallerstein, 1992). A high "sense of coherence," the belief that one's world is comprehensible, meaningful, and manageable given available resources, has been found to affect people's appraisal of their situation and ability to make decisions, both of which are important for health (Antonovsky, 1979; Antonovsky, 1988; Wallerstein, 1992). In addition, the positive relationship between social support and health has been partially explained by the fact that support increases the sense of personal control by enhancing an individual's ability to access resources and solve problems (Heaney & Israel, 1997; Wallerstein, 1992).

The relationship of community-level empowerment to health has been less thoroughly studied; however, research on social networks, community psychology, community competence, and community development suggests that community empowerment does have a positive influence on health (Wallerstein, 1992). Studies in community psychology and community development have found that participation has a positive effect on physical and social conditions in neighborhoods, from clean-up and beautification to home repair, reduced crime, reduced exposure to environmental toxins, improved delivery of social services, and stronger health policies (Wallerstein, 1992; Wandersman & Florin, 2000). Participation also strengthens social networks. Health outcomes that have been identified as being associated with strong social networks include increased participation in health activities, more equitable relationships between providers and consumers, and enhanced community capacity (Heaney & Israel, 1997; Wallerstein, 1992; Wandersman & Florin, 2000).

Participation's Role in Democracy and Social Justice

Thus far, community participation has been seen as a means to an end. It is perceived as being desirable because it strengthens health programs and contributes to empowerment, thereby enhancing health. Participation has, however, also been viewed as an end in itself, as valuable per se (Jewkes & Murcott, 1998).

The Alma-Ata Declaration (WHO, 1978) asserted that people, individually and collectively, have a right and a duty to participate in the planning and implementation of their health care. Community participation, in this sense, is closely linked to democracy

where, in theory, all people have rights and the freedom to choose (Jewkes & Murcott, 1998; Sawyer, 1995).

O'Connor and Gates (2000), in writing about the Healthy Communities movement, stated that the participation of citizens in community decision-making represents a more "muscular" form of democracy than purely representational political decision-making. Participation transforms community decision-making from debate (issue-specific activism designed to produce a winner and a loser) to deliberation (a discussion process that seeks to identify converging values in an effort to achieve consensus), thereby developing trust and broader, more holistic, insight into community challenges. In addition, participation allows those who will be directly affected by a decision to have input into it. O'Connor and Gates observed that the American public is increasingly disillusioned with the present political process which they believe does not serve their interests. Community participation in health is one way to give decision-making power to the people and is consistent with the emphasis on self-responsibility for health (Jewkes & Murcott, 1998).

Also embedded in the notion of community participation as a human right is the principle of social justice. In order for people, especially the poor or marginalized members of society, to exercise their right and duty to participate in health care decisions, there must be a redistribution of power and resources (Arnstein, 1971; Sawyer, 1995). Participation cannot be achieved without equity – equity in the provision and accessibility of services and programs, as well as equity in relationships between health

professionals, policy makers, and community members (Barnes et al., 1995; Magilvy, Brown, & Moritz, 1999; Meleis, 1992; Rifkin, Muller, & Bichmann, 1988).

Thus, community participation is more than an intervention to improve the delivery of health services or to create empowerment. It is also an explicitly political activity that can radically, but constructively, challenge the way that health priorities are established and acted upon (Annett & Nickson, 1991).

Factors that Influence Community Participation

Community participation has been studied by investigators in many different disciplines and, although the research is both extensive and diverse, it can be organized into several basic themes. These include the measurement of participation, including the levels or patterns of participation; the effects of participation, including effects on the individual and on social conditions; members' experiences with participation; and the factors that influence participation. In this section, only the literature pertaining to factors that influence participation will be reviewed.

Wandersman and Florin (2000) observed that one of the major puzzles in the literature on citizen participation is "If participation is such a good thing, why don't more people participate?" (p.250). Despite much evidence showing the positive effects of participation on both individuals and their communities, relatively few people choose to participate in community groups (Wandersman & Florin, 2000). In attempting to answer this question, researchers have sought to identify who participates and who does not, why people choose to participate, and what characteristics of organizations facilitate or hinder

participation. Investigators have also explored the relationship between community characteristics and participation, although these studies are relatively rare.

Who Participates And Who Does Not?

Several studies have been designed to identify the characteristics of individuals who choose to participate. Within this literature are studies that have used demographic variables and studies that have used social psychological variables. Demographic variables, such as gender, age, race, and socioeconomic status, have been used to predict participation. Piven (1968) described several characteristics of the urban poor that limit participation. These included being crisis ridden, overwhelmed with concrete daily needs; not believing that they can affect the world in which they live; lacking information to scrutinize social policies; and lacking leadership capabilities. In a study conducted in Australia, Baum, and associates (2000) explored the relationship between demographic, socioeconomic, and health status variables and levels of participation. Their findings revealed distinct patterns of participation, with the lowest levels of participation associated with low income and educational levels. In addition, those least likely to participate were non-married, in worse health, of an older age, and male. Florin, Jones, and Wandersman (1986) found that, controlling for socioeconomic status, blacks were more likely to participate in voluntary organizations than were whites.

Although certain demographic variables, such as race and socioeconomic status, do appear to be associated with participation, these have not been found to have explanatory or predictive power (Wandersman & Florin, 2000). Some studies suggest that race, occupation, and education may be less relevant to participation than

characteristics that reflect investment in the community, such as homeownership, length of residence, being older, or being married (Wandersman, Jakubs, & Giamartino, 1981; Wandersman, Florin, Friedmann, & Meier, 1987).

Researchers have also explored the relationship between personality variables (social psychological characteristics) and participation. Wandersman and Giamartino (1980) found that the perception by residents of neighborhood problems, sense of community, neighboring behaviors, importance of the neighborhood, perception of personal ability to change the neighborhood, and locus of control all contributed positively to initial participation in a community association. Similarly, in a longitudinal study, Chavis and Wandersman (1990) demonstrated that sense of community had a catalytic effect on participation in block associations. Psychological empowerment has also been associated with participation (Zimmerman, 1990).

Why Do People Participate?

Rather than examining the characteristics of those who participate, some investigators have sought to identify why people choose to participate. The literature in this area includes research that is based in political economy or social exchange theories and in cognitive social learning theory.

Political economy theory and social exchange theory suggest that people will invest their energy only if they expect to receive benefits and if they perceive the cost of participation to be low (Prestby, Wandersman, Florin, Rich, & Chavis, 1990). Prestby and associates (1990) developed individual-level benefit and cost items based upon these theories. The benefit items included three personal benefits (saving money, learning new

skills, gaining information), three social benefits (making friends, gaining recognition, receiving support), and three purposive benefits (helping others, improving the block, fulfilling responsibility). The cost items included three personal costs (child care, time, night meetings), two social costs (giving up activities with family or friends, not feeling welcome), and two purposive costs (disagree with organizational goals, no organizational accomplishments). They applied these variables to the examination of participation in 29 voluntary neighborhood associations. Their findings revealed that more active participants reported receiving more personal benefits and, to some degree, more social benefits than less active participants. In addition, the least active participants reported significantly more social costs than more active participants. Thus, their findings supported the political economy and social exchange theories.

Chinman, Anderson, Imm, Wandersman, and Goodman (1996) also examined the relationship between participation, benefits, and costs but, rather than comparing high active and less active individuals, they compared high and low participating groups. In addition, they assessed members' perceptions of benefits and costs at two different points of time in the life of the coalition: at the formation stage and at the implementation stage. They found that the perception of costs and benefits by members of the high active group did not differ from those of the low active group during the formation stage, but that members of the high active group experienced more benefits and fewer costs than members of the low active group during the implementation stage. This finding suggests that regular attendance or more functional committees may contribute to a greater sense of benefits and a reduced perception of costs among members.

Cognitive social learning theory proposes that individuals will choose to participate in certain organizations based upon their personal characteristics (values, needs, personality) and the characteristics of the organization (such as purpose, efficacy, location) (Wandersman & Florin, 2000). Florin and Wandersman (1984) operationalized five cognitive social learning variables that had been described by Mischel (1973) to predict participation in neighborhood block organizations. The five cognitive social learning variables were referred to as skills, view of the situation, expectations, values, and personal standards. These were compared to a set of demographic and personality variables to determine which was a better predictor of participation. This study demonstrated that the cognitive social variables accounted for considerably more of the variance in participation than did the demographic and personality variables.

What are the Characteristics of Organizations that Facilitate or Hinder Participation?

Rather than examining the characteristics of individuals that influence participation, some researchers have chosen to study how organizational characteristics facilitate or hinder participation. Among the organizational characteristics found to be positively associated with participation are a high degree of structure (Prestby & Wandersman, 1985); role clarity (McClure & DePiano, 1983); and a shared process of decision-making (Prestby & Wandersman, 1985).

Butterfoss, Goodman, and Wandersman (1996) examined whether certain coalition characteristics (leadership roles, staff-committee relationships, organizational climate, decision-making influence, and coalition-community linkages) predicted member satisfaction, member perception of costs and benefits, and member participation

patterns. Their findings showed that competent leadership, shared decision-making, linkages with other organizations, and a positive organizational climate (cohesive, task-oriented, and innovative) were important in determining member satisfaction and participation.

The importance of these factors was supported in a similar study by Kegler, Steckler, McLeroy, and Malek (1998). They assessed whether eight factors associated with organizational processes (leadership, decision making, communication, conflict, costs and benefits, organizational climate, staffing, and capacity building) and four structural characteristics (membership profile, recruitment pattern, complexity, and level of formalization) were related to member satisfaction and participation. Factors found to be associated with higher levels of member participation were good communication and skilled members. Member satisfaction was positively associated with skilled staff, skilled leadership, good communication, and having more of a task focus.

What Characteristics of Communities Facilitate or Hinder Participation?

In their seminal paper on community participation, Cohen and Uphoff (1980) observed that the community context in which participation occurs has a subtle, yet powerful, effect on the levels and forms of participation that are possible. They described the context as including the physical setting, the history of the region, and the social systems that are present. Despite the potentially significant role of the community in determining participation, few researchers have chosen to study this.

Perkins, Florin, Rich, Wandersman, and Chavis (1990) commented upon the dearth of research exploring the physical context of participation. These investigators

developed a block-level model of physical and social predictors of citizen participation in crime-prevention associations. The variables in this model included (a) demographic characteristics, length of residence, and home ownership; (b) the built environment (defensible space); (c) crime rates; (d) the transient physical environment (signs of social disorder); and (e) social climate, which included neighboring behavior, informal social control, sense of community, the importance that residents place on the community and on working to improve it, perceived efficacy of collective action, perception of crime and other problems, and satisfaction with the community. The results showed that a combination of "catalysts" in the physical environment (e.g., poorly maintained properties) and "enablers" in the social environment (e.g., block satisfaction and neighboring behavior) were significantly related to citizen participation. In fact, this study found that the factors that contributed most to block-level participation were those related to the social and physical environment, rather than the demographic characteristics or crime-related problems, perceptions, and fears.

Community size and degree of isolation are also factors that may influence participation. In a paper comparing rural and urban community development, Voth and Jackson (1981) wrote that the sparse populations and isolation of rural places have resulted in a social structure that tends to be characterized by homogeneity, informal patterns of interaction, and small institutions that are not as hierarchical as urban institutions. Such an environment is "conducive to participation and to the practice of citizenship and leadership by a large proportion of the population" (p. 3). However, the small scale of rural institutions can also serve to limit their effectiveness. Many rural

governmental institutions are operated by amateurs, who work part-time, assume multiple roles, and lack the skills required for public administration. In addition, rural communities often do not have the economies of scale or the tax base to provide the services needed for community development. Thus, the small size and low density that characterize rural communities support a high degree of citizen participation yet may, at the same time, significantly restrict the potential of participation.

Rural Health Beliefs and Practices

Another component of the community context that may be important in determining the levels or forms of participation is the culture. No studies were found that explored the influence of culture on participation. However, the literature on health beliefs and practices of rural residents suggests that a rural culture exists and that this has an effect on the health-seeking behaviors of rural residents. It was thought that these same cultural characteristics might also influence participation in a rural health development initiative. Thus, a second literature review was conducted for the purpose of identifying cultural factors that might be relevant for this investigation.

The Concept of Health

Researchers studying rural Americans have noted that rural dwellers tend to perceive health in a manner that is different from their urban counterparts. For rural people, health is often equated with the ability to work. This concept of health has been found in rural populations of varying ages, genders, and geographic locations (Long, 1993). Long and Weinert (1989), reporting on an ethnographic study conducted in Montana, observed that, for rural dwellers, work is of primary importance and health

asked rural citizens to describe their vision of a healthy community and found that economic reasons were one of two primary issues mentioned. Health services were deemed as being important because of their economic value to the community. The second characteristic that was frequently cited by these rural residents was social support (e.g., residents supporting each other). The value placed on caring for oneself and one's family and neighbors will be discussed next.

Self-reliance

The desire to care for oneself and to be responsible for oneself is a characteristic that has been observed by many researchers who have studied rural populations (Counts & Boyle, 1987; Long, 1993; Long & Weinert, 1989; Thorson & Powell, 1992). In their study of rural men, Sellers and associates (1999) found that the men exhibited individualism, self-reliance, and a strong locus of control. On the other hand, Stein (1982) argued that these values, although highly prized and asserted by rural people, are actually held in check within rural culture because of their potential to be disruptive to family stability. In the Midwestern farm families that he observed, Stein found that consensus and oneness of thought were viewed as essential to economic survival. This belief was so strong that Stein stated that he was tempted to characterize the farm family as a merger of self-interest with family-interest. The need to be independent was still evident, although it occurred at the level of the family. Stein commented that the wheat farming families wanted to take care of themselves and not be dependent upon anyone outside of the family.

The significance placed on taking care of oneself and one's family may be a result of the experience of living in geographic isolation with limited resources. Long (1993) noted that lack of health insurance, long distances from heath care providers, and land-based work that does not permit "sick days" influence the way that health is viewed and that health care needs are addressed. Rather than seeking help from the formal health care system, rural dwellers have a tendency to use informal networks of family members, friends, and neighbors to diagnose and treat health problems. Stein (1982) stated that, traditionally, the family *is* the health insurance.

Insider vs. Outsider

Rural residents use informal networks for health advice and assistance, not only because these are accessible and affordable, but also because the help received comes from "insiders" (Long, 1993). Ethnographic data gathered by nurse researchers in Montana indicated that rural residents organize their social environment in terms of the concepts of "insider/outsider" and "old-timer/newcomer." Length of residence, family history, and occupation determined the category to which people were assigned. Rural dwellers reported seeking health care advice from lay persons (such as Sam, the general store manager, who has "been here all his life and knows us and what we need") rather than from health professionals who were new to the community (Weinert & Long, 1987, p. 453).

The success of the Kentucky Homeplace Project, a health promotion program serving residents of Appalachia, was partially attributed to the fact that it was administered by people who had backgrounds similar to the clients they served and who

were familiar with local conditions (Schoenberg, Campbell, Garrity, Snider, & Main, 2001). This success contrasted to the failure of other programs that were rejected by the target population because they had been created and administered by "outsiders".

Health-Seeking Behavior

Rural values and beliefs, as well as the realities of the rural life-style, are reflected in health-seeking behaviors. Researchers have reported that rural residents delay seeking health care, often until they are very ill (Long & Weinert, 1989; Sellers et al., 1999). Lee (1993) attributed this to the hardiness, self-sufficiency, and independence that are characteristic of rural people. However, delays in seeking care also appear to be associated with work patterns. For example, health providers and researchers have observed that rural residents do not seek health care during the harvest season (Long & Weinert, 1989; Stein, 1982). Based upon his observations of Midwestern farmers, Stein (1982) hypothesized that the temporal context mediates the farmers' perceptions of susceptibility to disease, severity of disease, and efficacy of recommended health action, and thus influences their decisions to seek health care.

Furthermore, research suggests that rural people do not perceive a connection between use of the medical system and health maintenance. Only one quarter of the rural Nova Scotia women studied by Ross (1982) thought that health professionals could be useful in providing health advice and health assessment. One woman interviewed stated, "Health is not a topic to discuss with doctors and nurses" (p. 309). This finding was supported by Arcury, Quandt, and Bell (2001) who noted that, for most of the rural elders

they interviewed, seeking medical care was perceived as something you did when you were ill rather than an activity for maintaining health.

Summary of the Background for the Study

Community participation is widely supported within the public health community and has been extensively studied by researchers in many different fields. Most of the research aimed at identifying factors that influence participation has focused on the individuals who have chosen to participate or not to participate. Some investigators have sought to describe the characteristics of participants versus non-participants, while others have explored the decision making process that people use in deciding whether or not to participate. In recent years, attention has been directed to the study of community organizations or coalitions and how characteristics at the organizational level support or hinder participation. Very little research, however, has focused upon the characteristics of communities that may influence participation.

The physical setting, social structure, and culture of a community may have a significant influence on the forms or levels of participation that are possible, as well as on the outcomes of participation that can be achieved. The small size of rural communities, for example, increases the likelihood that people will know each other and may, as a result, enhance the overall sense of community, which could facilitate participation. On the other hand, small size also means that resources may be less available, which could, in turn, make it more difficult for people to participate or for participation to be effective. The tendency of rural residents to rely on informal networks for addressing their health care needs suggests that working together to solve community health problems may seem

natural to them. However, another common characteristic, distrust of "outsiders", may make it more difficult for health professionals to establish an effective partnership with community members, unless the professionals happen to be community residents themselves.

In order to engage rural communities in health development initiatives, it is important to understand the influence of rurality on community participation. Developing this understanding will come from examining how participation has been enacted in rural communities, and from identifying factors within the physical and social environment and the culture of the community that appear to hinder or facilitate participation. By exploring these issues, this research has contributed to the knowledge base and has set the stage for future investigations.

Conceptual Framework

The conceptual framework for this study of rural community participation was based on the ecological theory. One theorist whose name is often associated with the ecological theory is Urie Bronfenbrenner (1979). Bronfenbrenner proposed that human behavior is a consequence of the interaction between the person and multiple levels of influence within the environment. These levels of influence include the microsystem (the immediate environment of family and informal social or work groups), the mesosystem (interrelations among the settings in which the individual is involved), the exosystem (the larger social system), and the macrosystem (cultural beliefs and values). Thus, Bronfenbrenner understood behavior as not just the result of factors within the individual (knowledge, values, and attitudes), but also the result of factors in the environment,

including the people with whom one associates, the community in which one resides, and the culture in which one is embedded. Furthermore, the relationship between people and their environment is reciprocal. Not only do each of these subsystems affect behavior, but people, in turn, affect the subsystems (McLeroy, Bibeau, Steckler, & Glanz, 1988).

McLeroy and associates (1988) developed a variation of Bronfenbrenner's model to explain the adoption of health-promoting behaviors. Their model includes five levels of influence. These include intrapersonal factors, interpersonal processes, organizational factors, community factors, and public policy. Among the factors that are significant at the intrapersonal level in determining health behavior are knowledge, attitudes, and skills. At the interpersonal level, the social support received from family members, friends, and work acquaintances are important in influencing an individual's health behaviors. Organizational factors, such as work site conditions and policies, may also serve to support or discourage behavior change.

At the community level, several factors influence whether health promotion interventions are implemented, and thus have an indirect effect on individual health behaviors (McLeroy et al., 1988). First, communities contain "mediating structures," the informal social networks, churches, and grassroots associations to which individuals belong. These play an important role in determining the community's norms and values as well as individuals' beliefs and attitudes about health. Second, communities consist of organizations and agencies that may either work collaboratively to improve health or may compete with each other for resources. When resources are limited, as is the case in many rural communities, there is a tendency for increased competition among agencies

which, in turn, can lead to inefficiencies in implementing health promotion programs. Third, the power structures at local, county, or state levels often play a critical role in defining community health problems and allocating the resources to address these. It is the community power structures that decide what issues are placed on the public agenda, and these decisions may be politically motivated by economic or other interests. McLeroy and associates observed that the most urgent health problems in a community might be given little attention if the individuals or groups who experience these problems do not have access to the sources of community power.

Lastly, public policy also has an influence on the adoption of health-promoting behaviors. Regulatory policies and laws at the local, state, and national levels can, and have, contributed to health promotion through the establishment and enforcement of systems to reduce infectious disease (such as those related to sanitation and food and water quality) and by constraining behaviors known to have negative health effects (such as by banning smoking in public places, increasing the tax on cigarettes, and enforcing automobile seat belt usage) (McLeroy et al., 1988).

Community participation in health development, like personal health behavior, is a complex phenomenon that is influenced by factors at multiple levels. The ecological theory provides a useful perspective for considering the varied layers of influence on participation. Previous research has identified individual and organizational characteristics that are associated with participation. This study sought to identify factors at the community level that have an effect on rural community participation.

The conceptual model that was used to guide this research is shown in Figure 1. The model depicts three levels that may have an influence on participation. The focus of this research was on two sets of factors at the community level: cultural factors and factors related to the physical setting and social structure. The four cultural factors that were studied were (a) priority given to health, (b) perceived efficacy of collective action, (c) insider vs. outsider differentiation, and (d) sense of community and commitment to community. The four factors pertaining to the physical setting and social structure that were explored were (a) physical or structural barriers, (b) civic organization and experience with social planning, (c) leadership, and (d) resources. Each of these factors is defined in the section that follows.

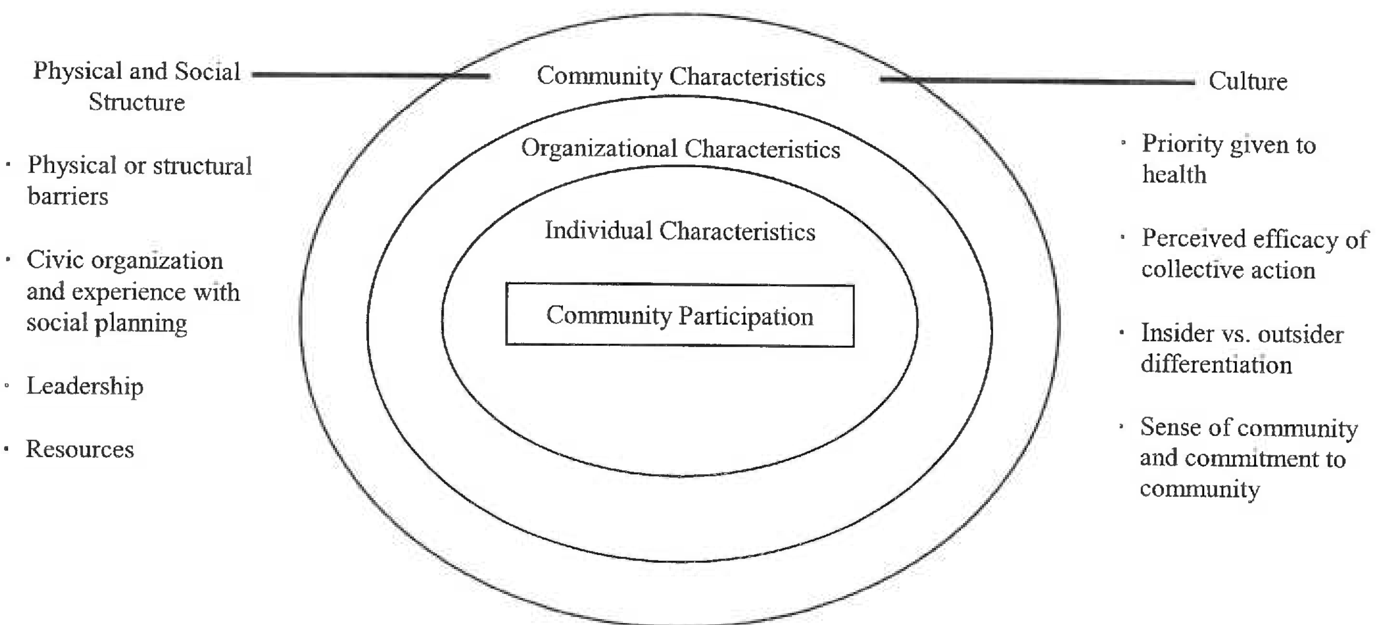


Figure 1. Conceptual Model of Factors Influencing Rural Community Participation in a Health Development Initiative

Definitions

For the purpose of this study, the following definitions were used:

Factors Pertaining to the Rural Culture

1. *Priority given to health* is a term that was chosen to refer to the priority assigned to health programs as compared to economic programs at the community level. It corresponds to the individual-level variable, perception of health. Perception of health has been defined as a person's ranking of health needs in relation to economic needs (Long & Weinert, 1989; Long, 1993; Lee, 1993).

2. *Perceived efficacy of collective action* is a community-level variable defined as the belief of community members in their ability to work together to solve problems (Chavis & Wandersman, 1990).

3. *Insider vs. outsider differentiation* is a phrase used to describe the degree to which community members, as a group, accept and trust individuals based upon their tenure in the community (Weinert & Long, 1987; Long & Weinert, 1989).

4. *Sense of community* is defined as a shared sense of membership in a community accompanied by informal mutual assistance (Chavis & Wandersman, 1990).

5. *Commitment to community* is a community-level variable defined as the importance residents place on their community and on working to improve it. Perkins and associates (1990) referred to this as "communitarianism".

Factors Pertaining to the Physical and Social Structure of Communities

6. *Physical and structural barriers* are defined as those features of rurality that may hinder individuals from being able to attend the community health development

activities, such as lack of public transportation, lack of child care services, and personal time limitations (Cohen & Uphoff, 1980; Kauffman & Poulin, 1994; Prestby et al., 1990).

7. *Civic organization* is defined as the presence of organized civic groups and grassroots associations (Goodman et al., 1998).

8. *Experience with social planning* is defined as the community's history of participation in efforts to address social problems (e.g., prior opportunities to engage in social planning and degree of satisfaction with planning experience) (Cohen & Uphoff, 1980; Goodman et al, 1998; Wandersman & Giamartino, 1980).

9. *Leadership* is defined as an attitude of local leaders, both formal and informal, that encourages participation, is inclusive, is willing to transfer power to others, and is receptive to prudent innovation and risk taking. Leadership also includes having skills in group process, conflict resolution, problem solving, program planning, and resource mobilization (Goodman et al., 1998).

10. *Resources* are defined as funding sources; physical space; and professional and technical personnel, services, and products (Goodman et al., 1998).

Assumptions

This study was founded on three key assumptions. The first assumption, derived from the review of previous research, was that community participation in health development initiatives is influenced by cultural and environmental characteristics, and that these characteristics can be identified and described. The second assumption, also derived from the literature review, was that community participation is a complex phenomenon with multiple dimensions, not a one-dimensional construct that is either

existing or not existing. The third assumption was that a multiple-site exploration of communities participating in a rural health development initiative in Oregon would provide valuable lessons about how rurality influences community participation and that these lessons would be beneficial to other health development programs.

Research Questions and Propositions

This research had three aims. The first aim was to describe how participation has been enacted within a rural community. To address this aim, a set of descriptive questions derived from Cohen and Uphoff's (1980) framework for community participation were used to guide the development of individual case study descriptions. The second aim was to identify factors within the culture of rural communities that influence participation in community health development. Four questions pertaining to cultural beliefs and values were used to structure the data collection and allow for comparison across cases. The third aim was to identify factors related to the physical setting or social structure that hindered or facilitated participation in community health development. Four additional questions were developed to guide the data collection relevant to these characteristics and, as with the second aim, to allow for comparison across cases.

Following the recommendation of Yin (2003), study propositions were also developed. The propositions reveal the manner in which certain characteristics that have been associated with rurality were expected to influence community participation. Thus, they correspond to the second and third objectives.

The research questions and study propositions pertaining to each of the study aims are listed below.

Aim 1: To describe how participation has been enacted within a rural community.

Question: How has participation been enacted in rural communities?

Community participation, according to Cohen and Uphoff (1980), is a phenomenon that has several dimensions. These dimensions include *What* (the kind of participation that is occurring), *Who* (the persons who are involved), and *How* (the process of participation). Each dimension is further broken down into variables that denote key components of participation, each of which may be more or less relevant in a given situation depending on the nature of the project that is undertaken and the context. The *What* variables represent the ways in which community members may participate in a project and include involvement in decision making; contributing resources to support project implementation; receiving material, social, or personal benefits as a result of participation; and participating in program evaluation. The *Who* variables pertain to who in the community is participating. Participants may include local residents or local leaders, both of whom are recognized as "insiders." Other participants may include "government personnel," the term that Cohen and Uphoff use to describe individuals who are more closely tied to a bureaucracy even if they are from the community, and "foreign personnel," who represent funding agencies or other large organizations outside of the community. Lastly, the *How* variables add a qualitative dimension to the assessment of participation and include the impetus for participation (did the initiative come from

within the community? is participation voluntary or coerced?), the form of participation (do people participate by being members of a group or can anyone participate? does one have to have certain skills or knowledge in order to participate and, if so, has this limited who can participate?), the extent of participation (the duration and scope of member involvement), and the effect of participation (whether participation is a formal activity with little meaning, or whether it has helped the members to gain control over situations of importance to them).

Cohen and Uphoff's (1980) model of participation was used as a guide for developing the individual case study descriptions of rural community participation in a health development initiative. In addition, the variables in the model were used as a means of assessing how each of the factors pertaining to the culture or the structure of rural communities had an effect on participation.

Aim 2: To identify factors within the culture of rural communities that influence participation in community health development.

Priority given to health

Question: Is the participation of rural communities in a health development initiative hindered because of limited support for health and health promotion?

Proposition: Rural communities prioritize health needs as secondary to economic needs which hinders their participation in a health development initiative.

The concepts of health held by individuals may affect their health promotion and health seeking behaviors (Smith, 1983). For example, people who conceptualize health

using a role performance model tend to associate health with the ability to work and thus may seek health care only when they perceive that they are not fulfilling their responsibilities. A significant body of literature has revealed that rural people assess health needs in relation to work roles and work activities (Long & Weinert, 1989; Long, 1993; Lee, 1993). For rural residents, health needs are usually secondary to work needs, and too great a concern for health is viewed as "doting upon oneself instead of making oneself useful" (Stein,1982, p. 97). *Priority given to health* is a phrase that has been chosen to refer to the level of support given to health at a community level. If the priority given to health is low, this may be reflected in the kind of participation that is occurring (e.g., inadequate resources contributed to the health development effort), in who participates (e.g., breadth of participation is narrow with members primarily from health organizations), and in how participation is occurring (e.g., the impetus may have come from outside the community and participation may have little meaning to members). This study examined the priority that rural communities assign to health and assessed whether this influenced their participation in community health development.

Perceived efficacy of collective action

Question: Is community participation in health development facilitated by perceived efficacy of collective action?

Proposition: Rural residents, as a group, have confidence in their ability to work together to solve problems which facilitates community participation in a health development initiative.

Studies in community psychology have shown that people are more likely to participate in a community association if they believe that they have competent colleagues who can be enlisted to support the project and if, by working together, they have the ability to solve local problems (Chavis & Wandersman, 1990; Wandersman & Giarmartino, 1980). At the same time, researchers exploring rural health practices have found that rural people are self-reliant and that they use informal networks of family members, neighbors, and friends to solve problems, including health problems (Long & Weinert, 1989; Long, 1993). If rural residents believe that they have the ability to solve individual health problems, they might also believe that, as a group, they have the ability to solve community health problems. The *perceived efficacy of collective action*, if it exists, has the potential to influence the kind of participation that is occurring (e.g., there is a high degree of citizen involvement in decision making relevant to health development and generous contributions of resources) and how participation is occurring (e.g., the impetus for participation is likely to have come from within the community and members are apt to view participation as a meaningful activity). This study explored whether rural residents believe they have a collective ability to solve health problems and assessed the influence of this belief on their participation in a health development initiative.

Insider vs. outsider differentiation

Question: Is rural community participation in a health development initiative influenced by whether leaders are considered an "insider"?

Proposition: Participation of a rural community in a health development initiative will be facilitated if the persons who lead the initiative are known by community members and accepted as "insiders."

Bracht and Tsouros (1990) noted that one variable that may inhibit or facilitate community participation is the degree of social acceptability of the change agent or group propelling the change. Researchers studying rural residents have found that rural people organize their social relationships in terms of the concepts of "insider vs. outsider" and "old timer vs. newcomer," and they are more willing to seek health care from someone who is recognized as an insider (Long & Weinert, 1989). Whether or not the person promoting the health development initiative is recognized as an insider may have an effect on who is participating (e.g., the number and breadth of participants) and on how participation is occurring (e.g., the amount of time that participants are willing to commit to the health development effort). This study assessed whether the leader was perceived as an "insider" or an "outsider" and explored whether this perception influenced community participation in the initiative.

Sense of community and commitment to community

Question: Is the participation of rural communities in health development facilitated because of a strong sense of community and commitment to community?

Proposition: Close relationships among neighbors and commitment to the community are characteristics of rural communities that facilitate participation in a health development initiative.

Research suggests that sense of community, neighboring, caring about the community, and willingness to commit time and energy to the community are positively associated with individual-level participation in community associations (Chavis & Wandersman, 1990; Perkins et al., 1990; Wandersman & Giamartino, 1980). Quandt, McDonald, Bell & Arcury (1999) observed that rural communities are more likely than urban communities to be characterized by a sense of community, reflected in a sense of membership, shared values, mutual influence, and emotional connection. If the sense of community and commitment to community are strong among rural residents, this may be reflected in the kind of participation that is occurring (e.g., the resources are contributed to the health development effort are perceived to be adequate or better), in who is participating (e.g., there are a large number of participants representing many segments of the community), and in how participation is occurring (e.g., the impetus for the health development initiative is likely to have come from within the community, members are willing to commit time to participation, and participation is meaningful to participants). This dissertation explored the sense of community and commitment to community in rural communities and whether these characteristics influenced community participation in a health development initiative.

Aim 3: To identify factors in the physical setting or social structure that influence participation in community health development.

Physical or structural barriers

Question: Is broad-based participation in rural community health development hindered because of physical or structural barriers?

Proposition: Rurality presents barriers (e.g., distance, lack of public transportation, lack of child care, time constraints) that make it difficult to achieve broad-based community participation in health development initiatives.

The literature in community psychology and rural community development suggests that physical or structural barriers may hinder participation. These barriers include lack of time (due to occupation or meetings held at an inconvenient time), limited resources (lack of child care), limited mobility (reduced physical mobility or lack of transportation), or physical constraints (distance, poor roads, and residents living in isolated places) (Cohen & Uphoff, 1980; Prestby et al., 1990). If barriers are present, they may have an effect on who is participating (e.g., membership may be smaller or less diverse) and on how participation is occurring (e.g., the time that members can commit may be limited). This study explored the physical and structural barriers that were present in rural communities and examined whether these influenced the development of broad-based participation.

Civic organization and experience with social planning

Question: Is the participation of rural communities in health development hindered because of limited social organization and experience with social planning?

Proposition: Participation is hindered in rural communities because of few civic or grassroots associations and limited experience with social planning.

The relationship between social organization and community capacity has been described by Goodman and associates (1998). These authors noted that organized civic groups and active, responsive mediating structures such as churches and grassroots organizations are important because of the role they play in facilitating neighborhood connectedness and in representing individuals in their interactions with formal agencies. Furthermore, a community's prior experience with participation in social planning will influence current willingness to participate (Bracht & Tsouros, 1990; Cohen & Uphoff, 1980; Goodman et al, 1998). Rural communities, because of their small size, may have few civic or grassroots organizations and limited experience with social planning. If this is true, this may have a negative impact on the kind of participation that is occurring (e.g., the degree of involvement in decision-making may be low), on who is participating (e.g., few people may choose to participate), and on how participation is occurring (e.g., residents ability to participate may be limited due to lack of knowledge or skills in planning). This study assessed the civic organization of rural communities and their experience with social and health planning, and explored whether these characteristics influenced their participation in a health development initiative.

Leadership

Question: Is rural community participation in a health development initiative hindered by the lack of effective leadership?

Proposition: Rural communities lack effective leadership, which hinders their participation in community health development.

Goodman and associates (1998) described participation and leadership as being two important and related aspects of community capacity. Capacity is enhanced through participation when leaders, both formal and informal, invite the involvement of a diverse network of community residents, are willing to transfer power to community members, and seek to develop new leaders (Goodman et al., 1998). Leaders also enhance capacity when they are receptive to prudent innovation and risk taking, and when they are skilled in group process, conflict resolution, problem-solving, program planning, and resource mobilization.

Participation and community capacity may be constrained in rural areas because of ineffective leadership. Voth and Jackson (1981) observed that most rural governmental institutions are operated on a part-time basis by persons who do not have specialized training in public administration and lack the skills necessary to develop citizen participation. In addition, the lack of anonymity in rural communities combined with a general resistance to change and pressure to maintain the status quo, means that rural leaders are often reluctant to address controversial problems or make decisions that could result in confrontation or conflict (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999; Veblen-Mortenson et al., 1999; Voth & Jackson, 1981). If a rural community lacks effective leadership, this may have a negative influence on who is participating (e.g., the number and diversity of members may be limited) and on how participation is occurring (e.g., the impetus for participating is likely to have come from

outside the community and the scope of activities undertaken may be limited). This dissertation assessed the effectiveness of local leadership and explored whether leadership influenced community participation in a health development initiative.

Resources

Question: Does the shortage of professional, technical, and financial resources available to rural communities hinder participation in health development activities?

Proposition: Rural communities have limited professional, technical, and financial resources, which hinders their ability to participate in health development.

Communities need funding from both local and outside agencies, competent professionals such as lawyers and accountants, facilities and meeting spaces for programmatic activities, and technological resources in order to increase community capacity (Goodman et al., 1998). If a community lacks resources, this may affect the kind of participation that is occurring (e.g., a lack of professional resources may limit the community's ability to be fully involved in decision-making, or a lack of financial resources may restrict the ability of the community to contribute to the health development effort). In addition, the lack of resources may influence how participation is occurring (e.g., the number of projects or activities that can be undertaken may be limited). This dissertation sought to examine the adequacy of resources available to rural communities and to explore the ways in which the availability or lack of availability of resources influenced community participation in a health development initiative.

Summary

In summary, rurality may have a significant influence on community participation in a health development initiative. This study explored how participation was enacted in rural communities, and sought to identify factors in the physical and social environment and the culture of rural communities that hindered or facilitated participation.

CHAPTER III

METHODOLOGY

The purpose of Chapter III is to describe the qualitative methods that were used for this study of rural communities that were engaged in community health development. This chapter presents the research design, case selection, and techniques for data collection and data analysis. Human subjects considerations are also described.

Research Design

A multiple-case study design was used to investigate the influence of rurality on community participation in health development. The design featured three cases of rural communities that were engaged in a community health development initiative. Qualitative approaches were used to gather data that described how participation had been enacted in these rural communities and to identify community characteristics that hindered or supported participation in the initiative. Data from each case were analyzed individually and comparisons were made across cases.

Yin (2003) defined the case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p.13). Case studies are appropriate when the goal of the research is to explore a contemporary phenomenon about which little is known and over which the investigator has little or no control. In addition, case studies are useful when contextual conditions are not easily distinguished

from the phenomenon of interest (Yin, 2003). A particular strength of the method is the use of multiple sources and techniques in the data collection process.

The multiple-case design is a sub-set of the case study strategy, offering distinct advantages and disadvantages over the single-case design (Yin, 2003). The evidence from a multiple-case design is usually considered to be stronger or more compelling; thus, the overall study is deemed as more robust. On the other hand, multiple-case studies require more resources and time to complete than do single-case studies.

The rationale for choosing the multiple-case study design for this research was three-fold. First, the intent of the study was to explore the relationship between a contemporary phenomenon and its context—community participation in a rural setting. Second, the investigator did not plan to control community conditions or behaviors. The goal was to understand the process of participation, not to evaluate or influence it. Third, the multiple-case study design offered the advantage of being able to conduct an in-depth exploration of each individual community, while also comparing findings across cases. The cross-case comparison made it possible to observe whether the findings had relevance or applicability beyond an individual case and, more importantly, it enabled the development of a deeper understanding of the conditions under which the propositions were or were not supported (Miles & Huberman, 1994).

Sample and Setting

Sampling

Criterion sampling, a form of purposive sampling, was used to select cases for this study. Purposive sampling strategies are consistent with a naturalistic paradigm and are useful when the intent is to select cases that exemplify a phenomenon and to obtain

information about the cases that may be particularly enlightening (Denzin & Lincoln, 1994). With criterion sampling, the investigator establishes a criterion and then identifies cases that meet this criterion. The communities selected as cases for this study were required to meet two criteria: rurality and participation in a health development initiative.

In case study research, the goal of sampling is not statistical generalization, where inferences are made about a population based upon data gathered from a sample, but instead is "analytic generalization" in which a previously developed theory is used as a template with which to compare the results of the case study (Yin, 2003). Each case study is considered to be a "whole" study, where facts are gathered from various sources and conclusions are drawn on those facts. Multiple-case studies are, thus, viewed as multiple experiments, and replication logic, rather than sampling logic, is used to guide the selection of cases. Each case is carefully chosen to predict either similar results (a literal replication) or contrasting results but for predictable reasons (a theoretical replication) (Yin, 2003). For this study, the cases were selected based upon a literal replication logic, where similar results were predicted.

Case Selection

Stake (1995) observed that the first criterion in case selection should be to maximize what can be learned. For this study, the goal of sampling was to choose cases that would be useful in understanding the influence of rurality on community participation in community health development. Thus, as noted previously, the communities chosen for this study were required to meet two criteria: (a) rurality, and (b) participation in a health development initiative.

Rurality was operationalized at the community-level as a community with a core census tract that has been classified as seven to ten on the Rural-Urban Commuting Area (RUCA) scale with no primary or secondary commuting flow greater than 5% to an urban area and no secondary commuting flow greater than 30% to a large town. These particular codes were chosen in order to limit the sample to communities with small populations and that were unlikely to have access to urban resources or to be influenced by urban culture.

The RUCA codes classify census tracts based upon size (Bureau of Census urban area and place definitions) and daily commuting patterns (Rural Health Research Center, 2002; USDA, 2002). There are 10 primary codes that reflect the size of the place and primary commuting flow. Census tracts with a small town (2,500 to 9,999 people) are coded as seven, eight, or nine. Rural areas (census tracts without a place of 2,500 people) are coded as ten. Each primary code is further subdivided based upon secondary commuting patterns (e.g., 5 - 30% or 30 - 50% commute to a large town or an urban area).

Participation in a community health development initiative was operationalized as having engaged, or being currently engaged, in the Community Health Improvement Partnership (CHIP) with on-going regular meetings of the partnership team. The CHIP program was an appropriate choice from which to draw the cases for this study because it was a health development initiative that was directed specifically to rural communities in Oregon and had a strong focus on involving citizens and developing local leadership. A description of the CHIP program follows in Chapter 4.

At the time of this proposal, three Oregon communities were engaged in CHIP activities, two had recently completed the CHIP planning process but were meeting regularly in an effort to implement their CHIP goals, and one community had completed CHIP and was no longer active. Thus, five cases met the study criterion of participation in a community health development initiative. Of these five communities, three also met the criterion of rurality as defined by this study. The rural criteria for these three communities, labeled as Communities A, B, and C, are found in Table 1.

Table 1.
City and County Population Size and Urban Influence of Communities Selected as Cases for this Study

Community	City Population[1]	County Population[2]	RUCA Code[3]	Distance from and Population of Nearest Larger Town[4]
Community A	4230	100,399	7.4	27 miles, 9580
Community B	9840	16,741	7.0	44 miles, 12,450
Community C	7420	44,479	7.4	30 miles, 9650

Note. [1] PSU, 2002; [2]U.S. Census Bureau, 2000; [3]Rural Health Research Center, 2002; [4]ORH, 2003

Data Collection

Preparatory Activities

The manner in which an investigator approaches a community and attempts to gain entry plays a significant role in determining the outcome of a project. Developing community acceptance and cooperation is challenging in any project where the researcher is not a member of the community and is unaware of community history and dynamics. This can be especially problematic in rural communities, where residents may distrust an investigator who is an "outsider" (Quandt, McDonald, Bell, & Arcury, 1999; Shreffler,

1999; Smith, Blake, Olson, & Tessaro, 2002). Thus, special strategies are needed to build rapport between the researcher and rural community participants. Because of the importance of these strategies to the implementation of this study, they were considered as part of the methodology.

The Office of Rural Health (ORH) at Oregon Health and Science University served as the link between the investigator and the communities selected as cases for this study. The ORH Community Services Manager was the individual responsible for providing training and support to the communities that are engaged in CHIP. Therefore, he was in a key position to facilitate the investigator's access to the communities. The investigator contacted the Community Services Manager by telephone early in planning phases of this study and sought his input regularly. In addition to introducing the investigator to the CHIP coordinators, the manager was helpful in providing background information on the CHIP program and the study communities.

For the purposes of this study, the CHIP coordinators were identified as the "gatekeepers", the people who were knowledgeable about their community's involvement in CHIP and who were in the best position to encourage participation in the study and to facilitate data collection. The ORH Community Services Manager, who had an established relationship with the CHIP coordinators, agreed to contact the coordinators concerning this study. Following this contact, a letter was mailed to the coordinators, describing the study goals as well as the potential advantages and disadvantages of participating in the study, and explaining what would be requested of them and of other members of the community if they agreed to participate (Appendix A). The investigator

also met with the coordinators prior to beginning the study to discuss the research in more detail and to identify individuals who met the criteria for key informants or focus group participants. In addition, the coordinators were given an opportunity to provide input into the questions that would be asked during the interviews. These suggestions were incorporated into the final interview guide.

The CHIP coordinators served as liaisons between the investigator and members of the community. Once the investigator and the coordinators selected people who were qualified to serve as key informants or focus group participants, the coordinators contacted these individuals to give them a letter that was written by the investigator describing the study and to invite their participation. After this initial introduction, all persons willing to serve as key informants were contacted by the investigator by telephone. The purpose of this conversation was to describe the study further, answer questions, obtain informed consent, and schedule a time for the interview. Focus group members were not contacted in advance of the interview, but were given an opportunity to ask questions about the study and to provide informed consent at the time of the interview.

Additional strategies that were used to build and maintain rapport between the investigator and the study participants included maintaining regular contact with the CHIP coordinators throughout the study and establishing a toll-free telephone number that community members could use to contact the investigator. All letters or summaries that described the study drew attention to the fact that the investigator was a nurse who lived and worked in a rural community. The investigator promised to share a summary of

study findings with the CHIP coordinator and offered to give a presentation, at the community's request, after the study was completed. In addition, those who participated in the study were assured that care would be taken to protect their confidentiality as well as the confidentiality of their community. Finally, the investigator sent hand-written notes to the key informants and focus group participants after the interviews were completed to thank them for their participation in the study.

Case Study Protocol

Data collection was guided by a case study protocol (Appendix B). Yin (2003) described the protocol as a major mechanism for enhancing the reliability of a case study. It is written to guide the investigator in carrying out the data collection from a single-case study, even if the single case is part of a multiple-case study. While it does not directly address cross-case comparisons, it plays an essential role in assuring that data collection is consistent across cases. The protocol for this study included an overview of the project, field procedures, case study questions, and a guide for the case study report.

Data Collection Methods

Interviews with key informants and focus groups were the primary data collection methods used for this study. Additional methods included document review and community observation. Table 2 shows the sources of data that were used to examine each of the major factors in this study.

Table 2
Study Factors by Data Collection Method

Factor	Interviews: Key Informants	Interviews: Focus Groups	Documents	Observation
Dimensions of Participation	X		X	
Priority Given to Health	X	X		
Efficacy of Collective Action	X	X		
Insider/Outsider Differentiation	X	X		
Sense of Community/ Commitment to Community	X	X	X	
Physical or Structural Barriers	X	X	X	X
Civic Organization & Experience with Social Planning	X	X	X	
Leadership	X	X		
Resources	X	X	X	X

Key informant interviews. At the heart of the data collection were interviews with key informants who were purposefully chosen for their knowledge of the CHIP partnership and the community's health-related activities. These individuals were expected to have the deepest understanding of their community's involvement in CHIP. A snowball sampling technique, starting with the CHIP coordinator, was used to identify as informants those who met the following criteria:

- Resided in the community served by CHIP;
- Were involved in some capacity in the initial decision to engage in CHIP;
- Were aware of the purpose, goals, and activities of the CHIP partnership team; and

- Were well informed of local planning efforts pertaining to health and of how health services are funded and supported in the community.

Twenty-one people, ranging from six to eight per community, participated as key informants in the study.

Semi-structured questions were developed to examine participation at each site while also enabling comparisons across sites. To facilitate an organized interview and to ensure that the data collection process was as consistent as possible, an interview guide was used (Appendix C). Although the key informants were asked to provide a response to each question on the interview guide, they were also encouraged to talk freely about their perceptions of factors that facilitated or hindered their community's involvement in CHIP. The goal was to achieve results that were comparable while, at the same time, allowing enough flexibility in the interview so that the unique aspects of each case could emerge (Patton, 2002).

The interviews were conducted in the community at a location convenient to the informant. Telephone interviews were arranged for those informants who were not available during the dates the investigator was in their community. Each interview lasted approximately one hour and, with the permission of the participant, was tape-recorded and later transcribed verbatim. Field notes were also recorded during the interviews.

At the completion of each interview, the investigator reviewed the audio-tape and compiled more extensive field notes. The purpose of the field notes was to record initial impressions of the interview as well as any questions or new ideas that may have been

generated. The field notes were maintained in an organized manner as part of a case study database.

Focus group interviews. In addition to the key informant interviews, six focus group interviews, two in each study site, were conducted with community representatives on the CHIP partnership team (e.g., those individuals who represented sectors of the community other than the health care sector). These individuals were not expected to have a deep understanding of the intent of the CHIP project or of their community's involvement in other health-related activities. However, it was anticipated that they would provide a somewhat different perspective on community characteristics and how these influenced participation in CHIP than that presented by key informants.

The criteria for selection of focus group participants were simply that they served on the CHIP team and represented a sector other than health care. In order to assure that the group size was manageable, a limit of six participants per group was established. Because fewer than six people agreed to participate in each focus group, all who expressed an interest were included. They included school administrators, small business owners, retirees, employees of social service organizations, and others from the non-health sectors of the community.

Before beginning each focus group interview, the investigator introduced herself, provided a brief overview of the topic, answered questions, obtained the participants' informed consent, and explained the "ground rules" for the discussion. The investigator also defined for the participants what she meant by "participation" in CHIP. This definition was provided as a handout so participants could refer to it (Appendix D).

Following the introductory comments, a sign was posted on the door to the room indicating that an interview was in progress and asking that no one enter. This was done in an effort to discourage any potential late-comers from joining the interview after the discussion began.

As with the key informant interviews, an interview guide was used to increase the consistency of data collection (Appendix C). The interview began with an "ice-breaker" question, inviting participants to introduce themselves to the investigator (Morgan, 1997). This was followed by a series of questions designed to elicit input on the factors included in the conceptual model. At the conclusion of the interview, the investigator provided a slightly more thorough overview of the purpose of the study and then asked participants if anything has been missed. Krueger (1998) refers to this as an "insurance question," since its purpose is to ensure that important aspects have not been overlooked.

The focus group interviews lasted between one to two hours and were audio-taped with the permission of participants. Following each interview, the investigator listened to the audio-tape and recorded field notes. The audio-tape, subsequent transcription, and field notes became part of the case study database.

Document review. Several public documents were reviewed to corroborate and augment the findings derived from interviews. Table 3 presents the data that were collected by the source and the purpose for which it was used.

Table 3.
Data Derived from Documents by Source and Purpose

Type of Data	Document Source	Purpose
Demographic data (population size; population break-down by age, ethnicity, percent below poverty level, and percent with high school diploma; average annual unemployment rate), primary industries, and distance from larger town	OHSU Office of Rural Health, U.S. Census Bureau, Chamber of Commerce	To provide background information on each community
Composition of CHIP partnership team by gender, age, ethnicity, and constituency/organization represented	Roster of CHIP partnership team members (requested from CHIP coordinator)	To assess *who is participating*
Evidence of community member input into decision-making (identifying needs, setting priorities, and planning programs) and which members are involved; frequency of meetings and regularity of members' attendance; number of activities undertaken by partnership team in past 6 months	Minutes of CHIP partnership team meetings from past year	To assess *what kind of participation* is occurring (e.g., extent of involvement in decision making) and *extent of participation* (e.g., duration of participation, time commitment)
Population mobility patterns, percent of home ownership	U.S. Census Bureau; Portland State University	To assess stability and homogeneity of community (part of *sense of community*)
Size of geographic area represented by CHIP; public transportation systems that are available, if any; percent of population who speak English less than "very well"	OHSU Office of Rural Health, U.S. Census Bureau, Chamber of Commerce	To assess *physical and structural barriers*

Table 3, continued.

Number of civic organizations, service clubs, community associations	Chamber of Commerce	To assess *community organization*
Number and variety of professional resources (lawyers, accountants, grant writers); number, size, and type of health care organizations	Chamber of Commerce, telephone book	To assess available *resources*

Community observation. Direct observation of the communities occurred through field visits to each case study site. An observational protocol was developed to guide field observations and was included as part of the case study protocol (Appendix B). Observations focused upon the physical environment, including geographic features, and availability and adequacy of resources such as meeting rooms, office equipment, and public transportation. Field notes taken during community observations were used as an additional source of data for the study.

Description of Interview Questions

Only the key informants, who, it was anticipated, would be most familiar with their community's involvement in CHIP, were asked questions concerning how participation was enacted. These questions were derived from Cohen and Uphoff's (1980) framework for community participation, which was described in Chapter 2. The questions focused on three dimensions of participation: *what* kind of participation occurred, *who* participated, and *how* did participation occur. To assess what kind of participation occurred, the key informants were asked questions about: (a) participation in decision-making (the extent to which community members were involved in identifying

local needs, setting priorities, and planning interventions to address these needs, and their comfort with this responsibility); (b) participation in implementation (the resources contributed by the community to support CHIP); and (c) participation in benefits (the number of projects that were planned or implemented as a result of CHIP). Because the CHIP process does not include an evaluation component, participation in evaluation was not examined. The "who" component was assessed by obtaining a roster of CHIP partnership team members and by asking key informants whether the diversity of the CHIP team reflected the diversity of the community. To evaluate how participation occurred, the key informants were asked questions concerning: (a) the basis of participation (where the impetus for CHIP came from); (b) the form of participation (how "target populations" were represented); (c) the extent of participation (the commitment of community members to the process); and (d) the effect of participation (whether the community viewed CHIP as being worthwhile).

Both the key informants and the focus group participants were asked questions concerning community characteristics and how these influenced participation in CHIP. The questions were derived from the conceptual framework, which, in turn, was based upon previous literature. A brief description of these questions follows:

Priority Given to Health

The respondents were first asked where health was ranked in their community in comparison to other concerns, such as economic development, environmental issues, or infrastructure. They were also asked to describe the community's primary health-related

concerns. Finally, they were asked whether the priority given to health in their community had influenced participation in CHIP.

Perceived Efficacy of Collective Action

To assess this variable, the respondents were asked whether most residents believe that, by working together, they can bring about improvements in the community. They were then asked if residents believe they have the collective ability to improve community health. Lastly, they were asked if the residents' perception of the efficacy of collective action influenced community participation in CHIP.

Insider vs. Outsider Differentiation

The respondents were first asked to identify the person or persons who were most likely to have been perceived as being the CHIP leader. They were then asked if these individuals were well known among residents and accepted as insiders. Thirdly, they were asked if the residents' perception of the CHIP leader as being either an insider or an outsider had hindered or facilitated participation in CHIP.

Sense of Community and Commitment to Community

The respondents were asked if the sense of community was strong in their community, whether residents felt connected to their neighbors and to the place, and whether the community was integrated. They were also asked if residents were willing to work on behalf of the community. Finally, they were asked if these feelings about the community had an effect on their community's participation in CHIP.

Physical and Structural Barriers

This question was introduced by explaining to the respondents that some communities have found it difficult to involve representatives from all key sectors in a

health development initiative because of barriers that prevented or hindered certain groups from participating in meetings or activities. They were then asked if they were aware of any physical or structural barriers that might have hindered sectors of the community from participating in CHIP. In instances where barriers were reported, respondents were asked additional questions to assess the ways in which participation may have been impeded.

Civic Organization and Experience with Social Planning

The community's level of civic organization was assessed by asking the respondents if voluntary organizations, such as fraternal organizations, church groups, or school groups, were popular. The community's experience in planning was evaluated by asking respondents whether the community had engaged in health planning or other forms of social planning prior to CHIP and, if so, whether these efforts were perceived positively or negatively by residents. Respondents were also asked if either of these factors had had an effect on their community's participation in CHIP.

Leadership

To introduce this question, the respondents were first told that, in this study, "leadership" referred to anyone in the community who was appointed to a leadership position or who was influential in community affairs. They were then asked to describe the community's leadership. The investigator asked further questions, as necessary, to elicit a more detailed response concerning whether the leadership, as a whole, was innovative, bold, inclusive, and competent in management, and whether the community's

leaders were interested in health concerns. Respondents were also asked if the strengths and/or weaknesses of the local leadership had influenced participation in CHIP.

Resources

Finally, the respondents were provided with a list of resource categories (Appendix D) and were asked to describe whether the resources available to their community had been adequate to support the CHIP planning process. They were also asked to consider whether the resources were sufficient to implement the CHIP goals.

Human Subjects Considerations

The research proposal was submitted to the Institutional Review Board (IRB) of the Oregon Health and Science University for approval. Because the research questions did not require participants to share information about their thoughts, behaviors, or health, or about their community's health status, the potential risks to human subjects were minimal. For this reason, the requirement to obtain signed informed consent was waived by the IRB. In lieu of a consent form, an informational letter was given to study participants (Appendix E). This letter was written by the investigator but was provided to participants by their local CHIP coordinator. Following distribution of the letter, the investigator telephoned all persons who had agreed to participate as key informants to describe the study in more detail, answer questions, and obtain each individual's verbal informed consent. Focus group participants were given more information about the study, had an opportunity to ask questions, and provided verbal informed consent immediately prior to beginning the focus group interview.

To protect the confidentiality of study participants, the names of those interviewed were not included in the database and the names of the communities were replaced with a letter (e.g., Community A, Community B, and Community C). However, because only six communities were participating in CHIP at the time of this study, the informants were advised that persons who were familiar with the CHIP program might be able to identify their community from the case descriptions.

Data Management

Yin (2003) stressed the importance of developing a formal, presentable case study database. The purpose of the database is to enable other investigators to review the evidence directly, if they should choose to do so. Thus, a case study database increases the dependability of a case study.

For this dissertation, a separate database was maintained for each case. The database included the raw data (e.g., audio-tapes, field notes, copies of documents), data that had been partially processed (e.g., interview transcripts, "write-ups", contact summary sheets), and analytical material (e.g., memos, coding schemes, data displays). In addition, the investigator retained documentation of decisions made and the steps taken to interpret the data both within-cases and across-cases. Data were cross-indexed using QSR N6, a computer software program designed for qualitative research, to facilitate the storage and retrieval of information.

Data Analysis

Data analysis occurred concurrently with data collection. Continual analysis of the data enabled the investigator to discover patterns that in turn led to new questions

about the influence of rurality on community participation in health development initiatives. The analysis consisted of three interwoven processes that have been described by Miles and Huberman (1994). These were data reduction, data display, and conclusion drawing and verification.

Data Reduction

Data reduction refers to the process of "selecting, focusing, simplifying, abstracting, and transforming" the raw data (Miles & Huberman, 1994, p.10). In this study, the raw data included audio-taped interviews, field notes, demographic data, meeting minutes, and other documents listed previously. These raw data were reduced through the process of writing summaries, coding, and writing memos. Specifically, the steps in data reduction were as follows:

1. Within one day after each interview, the investigator listened to the audio-tape, reviewed the field notes, and produced a "write-up". Miles & Huberman (1994) described the write-up as a coherent account of the interview that also includes the investigator's reflections and commentary.

2. In addition, within one to five days following the interview, a contact summary sheet was completed (Miles & Huberman, 1994). The contact summary sheet was a one-page form that summarized the main themes, new ideas, and questions that emerged from the interview (Appendix F). A copy of this form was attached to the write-up so that it would remain close to the data it summarized, and both documents became part of the case study database. Data from the contact summary sheet were also entered into a computer database.

3. At the same time that these actions were occurring, the audio-tape was transcribed into text by a professional transcriptionist. After the transcription has been completed, the investigator listened to the audio-tape again while reading the transcript to ensure that the text is complete and accurate.

4. Once the interviews had been transcribed, all of the case materials were coded following the technique described by Strauss and Corbin (1990; 1998) for open and axial coding. Open coding refers to the initial labeling and categorizing of data. During open coding, the data were broken down, examined, and compared for similarities and differences. Axial coding involved putting the data back together in new ways, making connections between the categories that were identified in the open coding process. Although open and axial coding are distinct analytic processes, they were carried out at the same time with the investigator alternating between the two modes. Initial sensitizing concepts were derived from the conceptual framework and research questions. It was anticipated that coding categories would change, develop, and become more specific as the field experience continued.

5. "Memoing" took place while data were being collected and analyzed. Memos, according to Miles and Huberman (1994), are primarily conceptual in nature. They reflect the investigator's ideas about how the data may be linked and, as such, they contribute strongly to the development or revision of the coding system. All memos written during the course of this study were dated and labeled so that they were retrievable.

6. Lastly, interview summaries and interim case summaries were completed. The interview summaries synthesized the findings from each key informant and focus group interview and included relevant quotes. The interim case summary included an overview of the site, a review of findings for the case organized according to the study aims and research questions, and puzzles or hunches that had emerged. A similar format was followed for each interview summary and interim case summary to facilitate within-case and cross-case analysis.

Data Display

Miles and Huberman (1994) define a display as being "an organized, compressed assembly of information that permits conclusion drawing and action" (p.11). They argue that valid analysis requires displays that are focused enough to permit viewing of the full, albeit condensed, data set and are arranged systematically to answer the research questions. The strength of such displays is that they enable the investigator to make comparisons, detect differences, see trends, and note patterns or themes. This study used both within-case and cross-case displays to facilitate drawing and verifying descriptive conclusions.

The checklist matrix is useful for analyzing data on a major variable or general domain of interest when the variable or domain can be broken down into distinct components (Miles & Huberman, 1994). The specified format is advantageous in that it facilitates systematic data collection, enables verification, and permits comparability across multiple cases.

Two checklist matrices were used in the early stages of within-case analysis. The first was used to answer the question of how participation has been enacted in each rural community (Table 4). The entries in columns labeled "dimensions" and "components of dimensions" were derived from Cohen and Uphoff's (1980) model of community participation. To complete the third column, "example", the investigator reviewed the transcripts, write-ups, and interview summaries; retrieved material by codes; and located relevant quotes. Both codes and quotes were entered into this column.

Table 4.
Checklist Matrix: Dimensions of Community Participation in CHIP.

Dimension	**Component of the Dimension**	**Example**
What Kind of Participation?	Involvement in Decision Making	
	Contribution of Resources	
Who is Participating?	Local Residents	
	Local Leaders	
	Outside Personnel	
How is Participation Occurring?	Impetus for Participation	
	Form of Participation	
	Extent of Participation	
	Effect of Participation	

A second checklist matrix was used to examine the factors within each rural community that influenced that community's participation in CHIP (Table 5). The factors listed in the first column were derived from the conceptual framework. Additional rows were added to the matrix as new factors were discovered. As with the previous matrix, data entered into the blank cells included codes and quotes extracted

from the transcripts, write-ups, and interview summaries. The "example" column contained a brief phrase to illustrate the factor. The column labeled "why important" included an explanation of the ways in which the factor influenced community participation in CHIP. Relevant commentary that facilitated understanding was entered as "remarks."

Table 5.
Checklist Matrix: Factors Influencing Community Participation in CHIP

Factor	Example	Why Important	Remarks
Priority given to health			
Efficacy of collective action			
Insider/outsider differentiation			
Sense of community/ commitment to community			
Physical or structural constraints			
Civic organization/experience with social planning			
Leadership			
Resources			

Lastly, a thematic conceptual matrix was used to more closely examine the relationship between the rural characteristics and dimensions of community participation for each case (Table 6). Miles and Huberman (1994) reported that this type of display is advantageous for bringing together data that "belong together" or are conceptually related. The format of this matrix was derived from the study's conceptual framework. Data describing the community's pattern of participation in CHIP were retrieved, as before, from the transcripts, write-ups, and interview summaries, and was entered as

codes and quotes into the empty cells in the matrix. The findings from the within-case analyses are presented in Chapters 5 – 7.

Table 6.
Conceptual Matrix: Rural Characteristics and Dimensions of Participation

Rural Characteristics	What Kind of Participation	Who Participates	How is Participation Occurring
Priority given to health			
Efficacy of collective action			
Insider/outsider differentiation			
Sense of community/ commitment to community			
Physical or structural constraints			
Civic organization & experience with social planning			
Leadership			
Resources			

After each case had been analyzed individually, cross-case analysis occurred. At first, the case-level charts were "stacked" to create large displays or "meta-matrices" (Miles & Huberman, 1994). Following the recommendation of Miles and Huberman, little order was imposed on the data at this point, and instead an effort was made to include all of the information from case-level displays in the meta-matrices. After studying the meta-matrices and using the research questions as a guide, data within- and across-categories was reassembled to create new displays. As new categories emerged, a summary table was developed to integrate the data across cases. In this study, the summary table was conceptually ordered, exposing trends or themes across cases and

adding clarity to core concepts. The findings from these cross-case comparisons are found in Chapter 8.

Conclusion-drawing and Verification

Conclusion-drawing occurs as regularities, patterns, and possible explanations or propositions are discovered. Miles & Huberman (1994) observed that conclusion-drawing actually begins early in the study as data are being collected. At first, the conclusions are vague but, over time, they become increasingly explicit. These authors also noted that conclusion-drawing includes verification, which involves going back to the data or re-working the matrices as the analysis proceeds. The process is continuous and iterative.

Miles and Huberman (1994) described several analysis tactics that can be used in drawing and verifying conclusions from the data displays. In this study, the following tactics were employed:

1. As the matrices were examined, similarities and differences were observed among categories. This is the analysis tactic of *noting patterns and themes*. Following the advice of Miles and Huberman (1994), the investigator looked for added evidence of these patterns and strove to remain open to disconfirming evidence.

2. *Clustering* is the process of inductively forming categories and the iterative sorting of "things" (e.g., events, processes, cases) into these categories (Miles & Huberman, 1994). At its most basic level, clustering relies on aggregation and comparison. Thus, it is interwoven with the creation and use of codes. The investigator

employed the technique of clustering and made an effort to verify the clusters and to avoid premature closure.

3. *Making contrasts and comparisons* is a well-accepted method of testing a conclusion. In this study, contrast and comparison were frequently employed. For example, one community's pattern of participation was contrasted with that of another community and the influence of one rural characteristic on participation was compared with that of other rural characteristics.

4. *Partitioning variables* was also employed as a tactic for analysis. Miles and Huberman (1994) advised that variables be "unbundled" in the early stage of the study, during conceptualization and coding, to avoid monolithism and data blurring. Partitioning was also used when one variable was not relating to another in the manner suggested by the conceptual framework.

5. Miles and Huberman (1994) described the tactic of *subsuming particulars into the general* as being similar to the "constant comparative method" that Glaser (1978) used in looking for "basic social processes". This tactic, which was employed in this study, is a conceptual and theoretical activity where the investigator moves back and forth between the first-level data and more general categories that develop through successive iterations until the category is "saturated."

6. Lastly, the tactic of *factoring* was employed. Factoring is the qualitative equivalent of factor analysis and involves the process of identifying the common element(s) in seeming disparate bits of data (Miles & Huberman, 1994). Factoring differs from noting patterns in that it occurs at a higher level of abstraction, with the end

result being a limited number of overarching themes or constructs. Miles and Huberman cautioned, however, that unless factors contribute to the understanding of the case or its underlying dynamics, they are useless.

Establishing Trustworthiness

The value and usefulness of a qualitative study depends on the trustworthiness of its findings. The evaluation of trustworthiness is, however, a subject of debate. At the present time, there is disagreement within the research community on the criteria that are most appropriate to use in assessing qualitative studies (Creswell, 1998). To evaluate this dissertation, the criteria described by Lincoln and Guba (1985) were used. These include confirmability, dependability, credibility, and transferability.

Confirmability

Confirmability, according to Lincoln and Guba (1985), is the naturalist's equivalent for objectivity and refers to neutrality and the limitation of researcher biases. To establish confirmability, the study methods, data sources, and logic used to interpret the data were carefully documented, a process that Yin (2003) referred to as "maintaining a chain of evidence" (p.105). In addition, three strategies recommended by Miles and Huberman (1994) were used to limit bias stemming from the researcher's effect on the case and the case's effect on the researcher. First, in order to reduce the sense of threat that informants might have felt related to their participation in the study, each participant was provided a letter that explained the reason for the study (e.g., that it was a doctoral dissertation), its purpose, the data that would be collected, and how the data would be used. Second, to assist the investigator to think conceptually and to remain focused on

the research questions, a case study protocol was used. Third, data were collected from multiple sources so the findings could be corroborated.

Dependability

Dependability is the qualitative parallel to reliability and refers to the consistency of the study and the stability of results over time and across researchers (Lincoln & Guba, 1985; Mertens, 1998; Miles & Huberman, 1994). Within the naturalistic paradigm, variances are expected, however it should be possible to track and explain these. In this study, two tactics were used to enhance dependability: the use of a case study protocol and the development of a case study database. The case study protocol not only served to keep the investigator focused on the research questions (thus enhancing confirmability) but also, by outlining the procedures to be followed in conducting the study, increased the dependability of the research (Yin, 2003). Likewise, the fact that raw data were maintained in an organized database increased the dependability of the findings by making it theoretically possible for other researchers to review the evidence directly (Yin, 2003).

Credibility

Credibility is concerned with truth value in qualitative research, and it parallels internal validity in quantitative studies (Lincoln & Guba, 1985). Credibility is concerned with whether the findings make sense, and whether there is agreement between the way the informants perceive their situation and the manner in which this is reported by the researcher (Mertens, 1998; Miles & Huberman,1994).

Examining exceptions to patterns is one approach that can be used to test the credibility of a study's findings (Miles & Huberman,1994). Two tactics for examining exceptions to patterns were employed in this study. The first involved following up on surprises (Miles & Huberman, 1994). The data were examined for examples that appeared to violate the study's conceptual framework. The second tactic involved looking for negative evidence (Miles & Huberman, 1994). If a pattern appeared to be emerging, the researcher actively sought data that would refute it.

Triangulation is another important strategy for enhancing a study's credibility. Miles and Huberman (1994) referenced Denzin (1978) in describing four types of triangulation. These include triangulation by data source, method, researcher, and theory. In this study, the use of multiple informants (data source triangulation) provided the opportunity to obtain different viewpoints concerning issues or events. And, although interviews were the primary data collection method, the data derived from observation and document review were used to corroborate the interview findings (methodological triangulation).

Lastly, feedback was sought from informants on the study's findings, a process that has been referred to as member checks (Mertens, 1998; Miles & Huberman, 1994). After the final data analysis, a synopsis of the conclusions was shared with the CHIP coordinator and feedback was invited. None of these individuals made corrections, however.

Transferability

Transferability is the qualitative equivalent for external validity (Lincoln & Guba, 1985). In qualitative research, the burden of determining whether a study's findings may be applicable to another setting remains with the reader of the research report. However, it is the investigator's responsibility to provide enough information to enable the reader to make this judgment (Mertens, 1998). Two strategies were used to enhance transferability in this study. First, the investigator made an effort to describe, in detail, the settings and processes that were part of the study sample (Miles & Huberman, 1994). This is a tactic known as providing "thick description." Second, the use of a multiple-case study design made it possible to observe whether the findings were replicated in similar sites, and thus contributed to the transferability of the findings (Yin, 2003).

CHAPTER IV

DESCRIPTION OF THE COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

The purpose of this chapter is to introduce the Community Health Improvement Partnership. How the process is initiated in a community, the roles of key participants, and the process for community decision-making are described.

The Community Health Improvement Partnership (CHIP) is a structured process for community health development that is offered to rural communities in Oregon by the Office of Rural Health (ORH) at Oregon Health and Science University. The purpose of CHIP is to engage community members in developing strategies to strengthen their local health care delivery system and improve community health status (McGinnis, 1999). This purpose is pursued through:

- Involving as many people as possible in the decision-making process;
- Expanding awareness of community health concerns, the challenges facing the local health care system, and the health resources available in the community;
- Creating programs and developing resources in response to identified community needs;
- Developing new local leadership; and
- Educating the community on the importance of the local health care system to the local economy.

Eligibility to participate in CHIP is determined by whether the community has a Critical Access Hospital and has an organization that is willing to sponsor the initiative. The sponsoring agency might be the hospital or it could also be another community organization such as the public health department, a community-based health clinic, or the city or county government. The sponsoring agency must demonstrate commitment to the ideals and goals of the process. In addition, participating communities are required to furnish half of the salary for the CHIP coordinator, as well as office space, equipment and supplies, and meeting space.

The CHIP program is supported with a grant from the federal government. When the grant was first received, the ORH notified the administrators of eligible hospitals of the availability of CHIP and other ORH services (personal communication, P. McGinnis, March 5, 2004). It was then generally up to the hospital administrator to contact the ORH if they were interested in CHIP. There have been occasions when someone from the ORH contacted the community and encouraged them to consider CHIP. Because of limited resources and the time-consuming nature of the process (CHIP lasts between 8 and18 months), the ORH accepts no more than two communities into the CHIP program at a time. If a hospital expresses an interest in CHIP and the ORH is able to accept another community, a staff person from the ORH meets with hospital managers and, often, the hospital board. The ORH staff person explains the program and the responsibilities that it entails. The hospital management team then decides whether they wish to participate.

The process begins with the employment of the local CHIP coordinator. The coordinator is hired by the sponsoring agency to facilitate and coordinate the CHIP activities and to promote citizen participation in health planning. In addition, community members are recruited for a CHIP partnership team. The partnership team members are responsible for gathering input from and communicating with residents from the community sector they represent. The ORH encourages communities to recruit team members from a wide variety of sectors. In addition to inviting health care providers, communities are urged to recruit representatives from the local government, business and faith communities, the education system, populations with special needs, and others.

The role of the ORH in CHIP is to provide training and technical support to guide the coordinator and the partnership team members through the process of community health development. Specifically, an ORH staff member provides training relative to the CHIP process, provides data and serves as a resource to the coordinator and team members, facilitates conflict resolution, assists the partnership to remain focused and to meet deadlines, and coordinates technical assistance from other outside organizations such as state or federal agencies.

CHIP is considered to be a structured process because of the sequencing of events and activities and the tools that are used for decision-making. However, the issues that are addressed and the projects or policies that are developed are not preconceived or planned. Decision-making is based on a review of quantitative and qualitative data. The quantitative data are provided by the ORH and include community demographic and socioeconomic descriptions, vital statistics, and statistics pertaining to utilization of local

health care services. Qualitative data are derived from individual and group interviews with community members. Each team members is asked to interview ten people from the community sector they represent. They are encouraged to include people who receive services as well as people who deliver services. For example, a team member representing the education sector is encouraged to interview students and parents as well as teachers and school board members. In addition, a community meeting is held so that the public-at-large has an opportunity to share their perceptions of the local health care system and their ideas for enhancing community health. The findings from the interviews and the community meeting are summarized in a report that, together with the statistical reports provided by the OHR, is reviewed by CHIP team members.

Once the assessment has been completed, an ORH staff member assists the CHIP team to prioritize the community's health needs. First, the concerns that were reported by community members are compared to the quantitative data, and the problems that are supported by both the qualitative and the quantitative data are identified and sorted into two categories: those pertaining to health care resources and those pertaining to community health status. Next, the team members use a forced choice process to select three priority health concerns in each of the two categories. During their deliberations, they are encouraged by the ORH staff member to consider the community's capacity for resolving each problem and to choose problems of varying levels of complexity or difficulty.

After the priorities are selected, the CHIP team members establish sub-committees to explore strategies for addressing each concern. The sub-committee

members decide on one or more strategies that they believe are appropriate for the community, determine a cost for implementing these, and provide a report to the full CHIP team. All strategies that are approved by the team become part of the final CHIP plan that is submitted to the sponsoring agency and to the ORH. If the ORH is confident that the plan addresses documented needs and has community support, they will provide a grant to the community to assist them in implementing the proposed projects. Once this occurs the planning phase is considered to be complete and the responsibility for implementing the plan rests with the community. The ORH is willing to serve as a resource for the community; however, their level of involvement diminishes significantly at this time.

CHAPTER V

CASE DESCRIPTION OF COMMUNITY A

This chapter provides a case description of Community A and its participation in CHIP. The chapter contains five sections. The first section briefly describes the community and where it was in its process of health development at the time that this study was conducted. The second section describes how participation in CHIP was enacted in this community. The third and fourth sections present community members' responses to questions concerning their community's culture and the physical and structural characteristics of the community, and they report how the respondents viewed these characteristics as influencing participation in CHIP. The chapter concludes with a discussion of additional community characteristics that were mentioned by the respondents as having facilitated or hindered participation in CHIP.

Community A Description

The region that is referred to as Community A was located in a remote section of western Oregon. Its boundaries corresponded to the service area of the local hospital. There were five towns in the region; the largest had 4230 residents (Portland State University, 2002). The population of Community A had been declining. In 2002, there were 7641 people residing in the region, which was down from 8632 in 1990 (Office of Rural Health, 2003). The largest town in Community A was located 72 miles from the nearest larger community (the county seat, population 20,170) and 82 miles from a city of

at least 50,000 residents. The region was linked to other communities by three single-lane, winding highways that followed the coast or traversed low mountains. Travel was slow and could be further impeded by heavy rain and fog.

Table 7 compares Community A to the state on several demographic characteristics. The residents of Community A were older, poorer, and less educated than residents of the state as a whole. Commercial fishing, timber harvesting, and a paper mill had once been the primary industries. However, the mill had closed, and fishing and logging had declined. The largest employer was now the hospital; a music software company and the school district were the second and third largest employers, respectively. Census data revealed that 19.3% of the population was employed in health, education, or social services (U.S. Census, 2000). Recreation (i.e., tourism) and related services were the second highest source of employment.

Table 7.
Selected Demographic Characteristics of Community A as Compared to Oregon[1]

Demographic Characteristic	Community A	Oregon
Median Age	47.3 years	40.0 years
Percent Below Poverty	15.8%	11.6%
Median Household Income	$26,778	$37,938
Percent Population Age 25+ without High School Diploma	19.6%	14.9%
Average Unemployment Rate	9%[2]	6.3%

Note. [1]ORH, 2003. [2] This figure reflects unemployment rate for the entire county, not Community A.

Community A became involved in CHIP in the fall of 2002. The hospital served as the sponsoring agency and employed the CHIP coordinator. Twenty-one people participated in the CHIP partnership team. Meetings were held monthly for a period of

nine months, beginning in December 2002 and ending in August 2003. At the time of this study, in the fall of 2003, the team had completed a community assessment, adopted a one-year plan of interventions to address key areas of need, and had received some funding to support implementation of the interventions. However, the CHIP coordinator had resigned and the team intended to wait until a new coordinator was employed before beginning to implement the projects. Plans were in place to recruit a new coordinator, but no action had been taken at the time that these interviews were conducted.

How Participation Was Enacted

The assessment of how participation was enacted focused on what kind of participation occurred, who participated, and how participation occurred. Table 8 summarizes the findings.

Table 8
Dimensions of Community Participation in CHIP in Community A

Dimension of Participation	Description
What Kind of Participation Occurred	
Participation in Decision-Making	Within the structure of the CHIP process, team members had full control over identifying needs and planning programs to address these. Many people provided input into the decision-making, although two respondents noted that input from "consumers" was limited. Team members were comfortable in making decisions.
Participation in Implementation	Community A furnished money, space, equipment/supplies, and labor. The hospital was the primary contributor during the planning phase and later provided funds for implementation.
Participation in Benefits	Four projects were slated for implementation; some funding was received. Several intangible benefits were realized: greater awareness of health matters, hospital is more supportive of community health, stronger social networks and enhanced collaboration, team members learned to "think outside the box".

Who Participated	The CHIP team was predominately White, middle-aged, female; 33% of the members were from health care sector. Many local leaders participated but involvement of community-at-large was limited. Elderly, Hispanic population, outlying communities, and men were under-represented. No low-income residents or youth on the team.
How did Participation Occur	
The Basis of Participation	Hospital administrator contacted the ORH to request information on CHIP. Hospital chose to become involved in order to broaden its mission and demonstrate its concern for community health.
The Form of Participation	Aim was to recruit leaders, people in authority from cross-section of community sectors. "Target populations" were represented by advocates and agency personnel.
The Extent of Participation	Participation in CHIP was burdensome for many because of the time that was required. However, attendance at meetings was strong and there was little attrition. Several team members volunteered to oversee project implementation.
The Effect of Participation	The community viewed CHIP as being important because of its connection to the hospital. However, whether CHIP will be perceived as being worthwhile will depend on their assessment of the outcomes. Since nothing had yet been implemented, residents were skeptical. The majority of team members were pleased with the plan that was developed.

What Kind of Participation?

To evaluate the kind of participation that occurred, the respondents were asked questions concerning participation in decision-making, participation in implementation, participation in benefits.

Participation in decision-making. Chapter 4 describes the decision-making process that is used in a CHIP initiative. Minutes of the partnership team meetings revealed that members reviewed statistical reports on local health status and health service utilization, and conducted interviews with community members in order to identify their community's health concerns. With guidance from an ORH staff member, they compared the concerns identified by community members with the quantitative data,

considered the community's capacity for resolving specific problems, and used a forced choice process to determine which health problems to target for intervention. Team members working in sub-committees then explored alternative strategies for addressing each health problem and selected the strategies they believed were most appropriate for their community. At the conclusion of the planning phase, the team determined how to allocate the funding they had received from the Office of Rural Health (ORH) and the hospital to the projects that had been proposed.

Residents not serving on the partnership team had an opportunity for input into the decision-making process as well. Each team member interviewed between five and eight people within their sector of the community; a total of 86 people were interviewed. In addition, approximately 100 community residents participated in the CHIP community meeting and shared their impressions of the health care system and their vision for a healthy community.

The majority of the people interviewed for this dissertation said that community members had full control over the decision-making process. As evidence of this, they pointed to the large number and the diversity of residents who participated in providing, gathering, and/or reviewing data:

> We had representatives from a variety of the community-at-large, not just the health care industry, but there were some there representing seniors, some there representing kids, a couple people from the schools … from the business community. So, this was a fairly large group … on the partnership team. It seems like there were about 30. I mean that was quite

> a large team. So that was from the whole spectrum of the community.
> And from that we did offer a community meeting and invite folks to come and, I don't remember how many ... [the coordinator] wanted a hundred. So I think the interests in the community were pretty well represented.

However, two respondents observed that the voice of "consumers" or the community in general, as opposed to community leaders, was limited:

> The people who were originally asked to be on the team were … business folks and service folks and one of the … questions I had about the process is that I didn't see much effort or focus on involving consumers like, say, people at the lower socioeconomic scale. . . .

Most of the respondents did not believe that the team's decisions had been affected by the presence of the ORH staff member. They described the ORH staff member's role as supportive but not directive. He was a resource for them and the CHIP coordinator, and someone who facilitated the process, but he did not influence the decisions that were made. However, one respondent said that the CHIP process itself restricted the community's options for decision-making. She noted that the team had little control over the data they reviewed or the questions that were asked of residents during the interviews and the community meeting, but stated that, once the priority health concerns were selected, the team was fully responsible for planning strategies to address these:

> I think that the group did feel like they decided on what we were going to fund. It was their decision, to fund and not to fund, and what would be

> incorporated in the plan at the end. I just don't think they had as much to say about how those initial choices were made ... were put forward in the first place.

Everyone who was interviewed agreed that the team members were comfortable with their role in making decisions. One person explained that, because many of the team members were employed in administrative positions, they were used to making decisions. Another pointed out that because this community is isolated, residents were accustomed to making decisions and taking care of themselves.

Participation in implementation.. As Chapter 4 described, communities that are interested in participating in CHIP must agree to furnish half of the salary for the CHIP coordinator, office space, meeting space, and equipment and supplies. In Community A, the hospital was the primary contributor to CHIP, providing funding for the coordinator's salary. The coordinator's office was located in a medical clinic that is owned by the hospital. A computer, phone, supplies, and postage were also provided by the hospital. The school district furnished the meeting space. The community also contributed considerable time to the CHIP process. Some residents who participated volunteered their time, while others were paid by their employers to attend the CHIP meetings.

The spaces provided to CHIP by the community were convenient, attractive, and comfortable. The coordinator's office was spacious and equipped with a filing cabinet, a desk and computer, and a small conference table. The school district's governing board room, which was used for CHIP partnership team meetings, was located one block from the coordinator's office. This was a large, nicely furnished room with a large table,

comfortable chairs, and access to bathrooms, coffee and water. A variety of equipment was available, including projectors, a screen, and a blackboard. Parking was ample and the building was wheelchair-accessible. Since the meetings were held in the evening when no other people were in the building, there was no problem with noise or interruptions.

Participation in benefits. The most obvious benefit to this community from their participation in CHIP was that four projects were slated for implementation. These included: (a) a prescription assistance program for seniors and low-income people; (b) a telephone reassurance program for homebound seniors and disabled persons; (c) a community wellness campaign with several strategies focused on improving fitness and nutrition; and (d) a health information and referral database. A grant of $25,000 from the ORH was matched in full by the hospital to fund the start-up costs for these projects. Some of this money was designated to employ a part-time coordinator to oversee implementation of the projects.

Several of the respondents mentioned social benefits that were also gained as a result of the community's participation in CHIP. Residents gained a greater understanding of community health and how to improve it, the hospital broadened its focus to become more supportive of community health, and social networks were strengthened as barriers between groups were broken down and people found ways to collaborate. In addition, two people mentioned that CHIP taught the team members to "think outside of the box" to explore new possibilities for solving problems.

Who Participated?

Twenty-one people served on the CHIP partnership team in Community A. According to the roster of members, seven of these individuals (33%) were men; 14 (67%) were women. All but one were Caucasian; one (5%) was Hispanic. Fifteen of the members (71%) were between 40 – 59 years of age, one (5%) was in her thirties, and five (24%) were sixty or older. Table 9 shows the constituencies or organizations that were represented by team members.

Table 9
Constituencies Represented by CHIP Team Members in Community A

Constituency or organization represented	Number of members
Health care	7
Business	4 (one person also represented the Hispanic community)
Seniors	3
Local government	2
Faith	1
Education	2
Low-income families	2

Others who participated in CHIP team meetings were the CHIP coordinator and an ORH staff member. The CHIP coordinator was a middle-aged Caucasian female. In her role as coordinator she represented the community as a whole. The ORH staff member represented his organization, which was located in a large city outside of this community.

Persons of Hispanic origin made up 4% of the total population of Community A, and 24% of the residents were 65 years of age or older (Office of Rural Health, 2003). Thus, the proportion of CHIP team members who were over 60 or who were Hispanic

closely mirrors the community as a whole. At the same time, it should be noted that there was just one Hispanic team member and one regularly attending member who was over 70 years of age, so the "voice" of these populations on the team was limited. Men and youth were under-represented on the team. Two-thirds of the team members represented constituencies other than health care.

Most of the respondents believed that the team was diverse in terms of the economic sectors that were represented but did not reflect the diversity of the community overall. Many local leaders participated in the team, but involvement of the community-at-large was limited. Several people mentioned sectors that were missing or under-represented. These included the low-income population, the Hispanic population, seniors, youth, young families, and residents of the smaller, outlying towns in the region. However, one person noted that team included a good mix of old-timers and newcomers, as well as retirees and working people.

How Did Participation Occur?

To evaluate how participation occurred, the respondents were asked to describe the basis for participation, the form of participation, the extent of participation, and the effect of participation.

The basis of participation. As Chapter 4 described, all rural hospitals that were eligible to participate in CHIP had been notified of this by the ORH. The ORH Community Services Manager explained that, in Community A, the hospital administrator approached the ORH, expressing interest in the program (personal communication, P. McGinnis, March 5, 2004). The ORH Community Services Manager

explained, "I really went for the top.... I wanted the people who had some authority...." For this reason, some groups, such as the low-income population, were not invited to participate in the team. She stated:

> We didn't have really low-income people. ... Because they're not up and coming leaders.... Even though [ORH] says it's also a leadership training, we didn't view it that way. We really tried to get people that ... could make things happen.

On this CHIP team, the groups that did not directly participate were represented by advocates or agency personnel.

The extent of participation. The minutes of the CHIP team meetings revealed that the team met nine times over a period of nine months. Three of the initial 21 members dropped out of the team. Two left for personal reasons but one dropped out because she found the time commitment too demanding. Of the remaining 18 members, fourteen attended seven or more of the team meetings and four attended five or fewer meetings. In addition to attending the team meetings, the CHIP members organized and participated in the large community meeting, reviewed reports, and conducted between five to eight key informant interviews.

All of the respondents, except for one, stated that the team members had made a significant commitment to CHIP. Words such as "considerable" and "a lot" were used to describe the time that was required. The fact that participation was burdensome is evident in the remarks made by one respondent who stated:

> You heard a lot of, you know, "how many times are we gonna meet" and "how much time is gonna be involved" and "is this on-going or am I gonna be able to quit doing it". So they were willing to hang in there, even though it went on and on, and they said "well, I thought ... this was gonna be done by now."

But, despite the burden, attendance at team meetings was good and there was little attrition in membership. The commitment made by the team members impressed many of the respondents. One said, "I think the commitment was really strong, and I think it's shown by the [fact that] we had very little attrition. To me, that's amazing, that for nine months people met at least monthly and sometimes more." Another noted:

> I was very impressed with the people there because these are people that are in administrative positions that have a lot on their plate. And I was impressed by how often they attended the meetings. Very few ever missed and our meetings were, I don't know, two hours, sometimes between maybe two to three hours of the night. And so I thought it was a pretty good commitment on their part and people were very involved in it.

Only one person said that the team members seemed unwilling to commit much time to CHIP and that attrition had occurred. Yet, she concluded that participation was quite good despite the fact that the meetings extended into the summer months.

The team members' investment in CHIP was further demonstrated by the fact that many agreed to remain involved after the planning phase had ended in order to oversee implementation of the projects. The CHIP chairperson noted:

> I was pleasantly surprised when we came to the final meeting and said we need to move forward and we need a council to go with us to kind of foster the coordinator, and what's going to happen. We didn't have any trouble having people say 'well, I want to follow it through because I've got some other things I want to make sure happen.

The effect of participation. A few people, when asked if CHIP was viewed as important, said that it was because it was associated with the hospital. They noted that residents were supportive of their hospital and had an interest in improving and expanding local health services. For example, one respondent said, "... people are so proud of their hospital here, in having their own hospital.... And ... there's always that fear of losing it. So ... if it's anything to do with health care or the hospital, they're "Johnny-on-the-spot."

However, the majority of the respondents stated that, despite the residents' willingness to participate in CHIP, their perception of whether it was worthwhile would ultimately depend on their assessment of the outcomes. Because the community had not yet been informed of the CHIP team's plan and none of the projects had been implemented, most of the respondents believed that residents would view CHIP with skepticism.

> I think that, at this point, the community in general [is] ... probably looking at it with a jaundiced eye. They're probably sitting back waiting to make their final judgment, "well, we're still waiting to see what comes out of it and then we'll let you know whether we think it's worthwhile".

Although the community in general was not yet convinced that CHIP had been worthwhile, several of the respondents reported that the team members were satisfied with what had been accomplished. One person noted, "It's amazing what we got done, actually". Another said, "I know that I was pleased.... At times, in the beginning, a bit skeptical, but in the end pleased ... with the outcome and the investment." A third person reported, "the prescription drug [program] blew me away because I didn't think we'd come up with something so ambitious, and we did" and later stated, "when you look at the projects more, they're pretty cool. There are some really neat ideas. And I think they can make a difference. I'm actually very pleased." These comments suggest that, from the perspective of those who were aware of the results, CHIP was perceived as worthwhile. However, one respondent expressed a negative opinion about the value of the CHIP outcomes. Her remarks imply that she believed these were unimportant or insignificant:

> I'm thinking ... "now, how important in the grander scheme of things are buying t-shirts [to promote a community fitness activity]?" And so that really struck me. That was kind of an "a-ha" at the end. ... If we would have found some big thing that we could wrap our hands around ... or be impassioned about. I think that was why I thought that CHIP would work . . . is that we're going to, in the end, come up with something that we can all rally around. . . But we heard some pretty wacky kind of things that we should be spending our money on.

The Influence of Cultural Characteristics on Participation

This section presents the respondents' descriptions of Community A relevant to four factors in the cultural environment. These factors include (a) the priority given to health, (b) the perceived efficacy of collective action, (c) insider versus outsider differentiation, and (d) the sense of community and commitment to community. The respondents' perceptions of how these factors influenced participation in CHIP are also discussed. Because not all of the respondents' comments were captured within the three-dimensional framework developed by Cohen and Uphoff (1980), a fourth dimension was added. This dimension, labeled *perception of the process*, includes the community's satisfaction or dissatisfaction with experience of participating in CHIP, with the CHIP methods, or with the CHIP leaders, both local and from the ORH.

Priority Given to Health

In Community A, variation was found in the perceived importance of health. All of the respondents believed that the priority given to health in the community was linked to economic and demographic conditions, but they differed in their assessment of how these conditions have influenced the interest in health.

Because industries and jobs have been lost in recent years, some people thought that the community's highest concern was economic development. One woman observed:

> I would say [health is ranked] . . . not very high. . . . I think people would say, "oh, jobs are more important and shopping is more important, and businesses…." Because jobs have been so tough, and the economy has

> been so bad. I think the people see those as bigger problems. That good health is kind of a ... not a luxury exactly but too ... fluffy. Not a hard issue.

On the other hand, because of growing numbers of retirees and people who are poor, some of the respondents believed that health was either increasing in importance, or was already very important, to the community. For example, one person said:

> That's difficult to answer because we like to think that it was a priority, you know, but I'm not sure it is until they need it. . . . But . . . with more and more retired people coming in . . . their health does become a priority . . . health needs are a priority.

Another commented, "I'd say it's right up there . . . because of your population . . . a lot of seniors. . . . And you have a . . . low-income segment where there's, from what I've heard, a need for mental health."

Being questioned about health prompted some of the respondents to speak of the community's commitment to the local hospital. It was noted that residents were proud of their hospital and feared that it could close. One person explained that, unlike people in urban areas who may take their hospital for granted, having a hospital is a concern for rural residents.

The health concern that was reported most frequently by the respondents in Community A was access to health care, and the majority of those interviewed doubted that health promotion was understood or valued. For example, one person said, "[W]hen we're talking about health – I mean, access to health care is one thing, but a healthy

community…?" Some of the respondents explained that health behaviors, including behaviors that create social problems, are considered to be "personal" and not a subject to be discussed. One stated:

> I would say that [access to health care is a greater interest than health promotion]. And maybe because somebody else was doing that, whereas health, you know … changing the way you and your family eat, changing the way you and your family exercise … is more personal, you know. Okay, let's talk about not smoking, let's talk about wearing your seatbelt . . . then you're starting to . . . make people uncomfortable because then they have to change. Where it's really easy to say we need another surgeon.

And another noted,

> The whole drug [problem] is an issue. . . . We don't chat about methamphetamine much in this community. We don't get to the heart of the alcohol. We don't get to the heart of the tobacco. I don't think folks want to talk about that much. Yeah. So it's a personal thing. That's what I mean when I say personal. People don't want to address it.

The community's interest in sustaining the hospital appeared to facilitate participation in CHIP in Community A. Many respondents mentioned that the large number of people who participated in CHIP was due to the fact that CHIP was associated with the hospital. One individual explained, "[T]here's always that fear of losing [the hospital]. So the people . . . if it's anything to do with health care or the hospital, they're

'Johnny-on-the-spot.'" And another said, "I think that was part of why we had such great participation is that people definitely want to keep this hospital."

On the other hand, the low interest in health promotion may have led some of the team members to perceive the CHIP goals, particularly those related to wellness, as being insignificant. A few people expressed disillusionment or were sarcastic when they spoke about the outcomes. For example, one respondent who had talked about the drug problem among the area's youth said, "[T]here was some humor in there for me because . . . the wheels extravaganza thing that people want to do, to buy t-shirts [to be used as an incentive for people to exercise]. I'm thinking . . . how important in the grander scheme of things are buying t-shirts?" And another observed:

> Certainly . . . the members of the team . . . [believe] that the projects we chose . . . can and will improve the health of the community. And getting people to walk a hundred miles . . . I'm not sure it's going to work for me, but it's a thought. [laughs] You know I bet we could invite Ben and Jerry's to donate ice cream. I'd walk a hundred miles for a pint of Ben and Jerry's. Probably kind of not. [laughing].

The low interest in health promotion may have been mediated, however, by CHIP. For example, despite the low interest in health promotion that was reported, one of the goals selected by the CHIP team was a community wellness campaign. One person explained this by saying that the CHIP team members, unlike the community as a whole, are interested in wellness. However, others believed that it was through their involvement in CHIP that the team members were educated about health promotion. One

respondent was hopeful that, now the team members had knowledge, they could become advocates for health in the community:

> I think [CHIP] raised consciousness for one thing. I mean, I think understanding even the relationship between poverty and health problems . . . was something that a lot of people had not made the connection. . . . What you do and what you don't do has an immediate impact on what your body is all about. . . . I don't think people got that at all. So I do think that the CHIP council can become advocates now.

This same individual noted that the hospital's management team had not previously supported efforts to improve community health but now, because of the momentum that was built through CHIP, they were committed to health promotion.

Perceived Efficacy of Collective Action

The majority of the people who were interviewed in Community A affirmed that most residents believe that, by working together, they can bring about improvements in the community. Some said that, because the community is isolated, the residents have learned that "we can't rely on anybody else to solve our problems; we've got to solve them ourselves. We've got to roll up our sleeves and get in here and do the job ourselves." Others noted that the community's history of accomplishment has given residents confidence in their ability to solve problems. For example, one person said, "I think they would feel that by working together that something could be accomplished because I think that's been proven in the town." However, a small number of the respondents did not think that the residents, as a whole, believed that collective action

would result in success. Two people noted that the CHIP team members were optimists but that the residents, in general, were "probably more blasé about it, kind of, 'we'll believe it when we see it.'" Also, one respondent described a "defeatist attitude" which, she thought, was prevalent in the community.

Most of the responses concerning the residents' beliefs about their ability to bring about improvement in the community's health were negative. Some people noted that the community had little experience in trying to improve health, therefore many were skeptical about whether this was possible. One person explained:

> I think that's a novel thing. We're used to improving parks, we're used to improving other stuff. I think health is . . . that's kind of a novel thought, that we could do anything about anyone else's health. So . . . we'll see.

Others mentioned that the community had experienced many program failures, where "things get started and then, all of a sudden, nothing happens" and this contributed to a sense of skepticism about creating programs to improve health. However, a small number of respondents said that the CHIP team members, unlike residents as a whole, believed that they could bring about changes that would improve health.

A few people believed that the community's sense of efficacy had facilitated participation in CHIP. One person noted that the team members' confidence in their ability to bring about change contributed to the high level of commitment to CHIP. Another said that it was reflected in the team's willingness to "take on a couple of pretty substantial projects". Two people attributed the good attendance at the community

meeting to the fact that the residents knew that the CHIP team members had been able to achieve successes in the past.

However, the community's skepticism about making health improvements had a greater impact on CHIP than did the sense of efficacy in general, although this impact was not completely negative. Because the team members were aware that residents were skeptical, they had a strong desire to "show results" – to produce a tangible outcome – in order to prove that health improvements were possible. One respondent said, "I think that if we show some results. And we don't wait two years to get something where they can actually physically see something then, yeah, [they'll be convinced]." Another observed, "well, if you don't show them something, the next time something comes along they're going to go 'eh, it's another one of those things'. We've got to show them results."

Achieving tangible results was important to team members as well. Several people noted that the team members questioned "what are we going to accomplish," and they insisted that they didn't "want to spent eight or nine months here for nothing to happen . . . except for somebody to generate a report, which gets put on the shelf."

For one respondent, who had doubts about the team's ability to bring about health improvements, the CHIP process had already proven its value. She explained:

> I think some people kind of wondered, could we do anything . . . I mean, the issues that were . . . the big one was the high cost of prescriptions, especially for seniors. And all of us said there's nothing we can do about that; we cannot do anything about that. Given the money that we have at

> the end, what can we possibly do to change that? And amazingly enough, they came up with something. … I mean, it's not what I think people expected—to give a prescription cheaper or to give them money to get prescriptions, which, I think, to me was the obvious thing. . . . So I think that, for me, that was kind of a good thing and the process showed me that sometimes you have to be thinking outside the box. That maybe you can come up with something else.

Similarly, the person who described the community as having a defeatist attitude did not think that this had hindered CHIP but noted, "that's why I think CHIP was somewhat unique. I mean, I do think we kind of forced ourselves to think out of the box. And I think that's the exception, not the common practice here."

However, two of the respondents who had commented on the community's experience with program failures, expressed pessimism about whether the CHIP projects would succeed. One said, "we want to hire a person to run a prescription program. I'm very skeptical that that's going to work. So, I could just go down the list of what the goals were and go . . ." At this point, she shrugged and sighed.

Insider vs. Outsider Differentiation

In Community A, the person who was most often mentioned as being the CHIP leader was the chairperson. The chairperson was fairly new to the community, having lived there for two and a half years; however, he held a public position and so was well known to the residents. The CHIP coordinator was also mentioned as being a CHIP leader, although several people described her role as that of a facilitator or support

person, rather than team leader. The coordinator's tenure in the community was similar to the chairperson's. She had lived there two years. However, unlike the chairperson, the coordinator was unknown to most residents prior to CHIP.

Although acknowledging that the chairperson was well known, the respondents differed in their opinions as to whether he was considered a community insider. One person stated that he had been accepted "because of the way he's earned respect through his actions and with his abilities." Another agreed that the chairperson was respected but said that "there's got to be people out there that resent the fact that somebody comes in new and, all of the sudden, is in such a position of authority or power." A third person doubted that the chairperson had been accepted as an insider. She said, "you know, we're not always sure about new ideas, especially from those new folks. So I don't know if he's perceived as an insider or not."

In reference to the coordinator, one respondent said that she had been accepted by the community because of "the way she handles herself [in CHIP]; is non-threatening, supportive; a good leader." However, the coordinator herself stated that people perceived her as a newcomer.

The majority of the respondents reported that participation in CHIP was not hindered, and may have been facilitated, by having a coordinator who was an "outsider". Several people stated that the coordinator's leadership skills and her willingness to involve and listen to community leaders were more important to the process than whether she was known. Also, a respondent who played a key role in selecting the coordinator

explained that she deliberately chose to hire someone who was unknown in order to avoid the perception that the CHIP process was biased:

> I . . . thought it was good to have an unknown as the leader because we all have our own baggage that we bring with us and our own . . . issues, and people have their issues with us. And having [the coordinator] as an unknown . . . she was kind of a clean, safe person. . . . No one knew if she had any axes to grind. . . . So I thought that seemed to be the best . . . to have somebody that was a non-entity so people would feel this was an unbiased, impartial process.

Another person's comments reinforced the notion that having a leader who was known could contribute to a perception of bias. He noted that the CHIP chairperson's ties to other local leaders who also served on the CHIP team had created an impression that the CHIP process was being controlled or manipulated:

> I had kind of mentioned to several of the people that—and this is not intended as a negative—but that, when you do get your people that are your shakers and movers, where these are the people that chair the Rotary Club committee, and these are the people that chair this committee, you have to watch that there's almost kind of some back-patting that takes place . . . you know, "yeah, you're a good ol' boy, and . . .we'll do this because you recommended it." . . . It was kind of, as I call it sometimes, the mutual admiration society . . . where . . . it's the same people that serve on all the committees and they already know kind of what the agenda is,

> and they're almost falling over each other sometimes to pat themselves on the back.

On the other hand, one person believed that having a coordinator who was unknown had been detrimental to the process. To her, the coordinator's status as an outsider meant that she could not be trusted. The fact that the coordinator resigned before the CHIP projects had been implemented confirmed to this individual that she was, indeed, not trustworthy.

> I have no relationship with her. I don't know if I can trust her. I don't know her organizational skills. I don't know her knowledge. . . . I mean, I don't know what she knows. She might smoke, drink, and have wild parties at her house, and she's trying to convince us that we should be doing this get-together health thing. Oh my gosh! I didn't know her at all. . . . I have to tell you, I think if [a long-term resident had been employed as the coordinator] . . . I think the whole thing would have looked different. . . . Because she's known, she's trusted, and she's out there. . . The process of getting things done would have been different. . . . I would of known . . . that she would follow through, that she was going to be here tomorrow. And look! Because [the coordinator] left . . . left us! Left this group that we had going on.

Sense of Community and Commitment to Community

The fourth cultural characteristic that was assessed was sense of community and commitment to community. The majority of the respondents in Community A described

the sense of community as being strong. It was noted that residents were "connected with each other" and were "very community-oriented and very eager to step up whenever the need arises to help someone else in the community." One person explained that the strong sense of community stemmed from being isolated and from the community's status as the "bastard child" of the county. Because of this, she said, residents have learned to take care of themselves and this has drawn them close. Only two of the people who were interviewed thought that the sense of community was weak. They blamed this on the disintegration of family life and said that, because families are no longer connected, the community isn't connected.

Despite the belief by most that the sense of community was strong, nearly all of the respondents said that divisions existed between sub-groups in the community. They described the community as being divided by socioeconomic status, by age, and by status as a newcomer or old-timer. It was also noted that the towns within Community A did not feel connected and, in fact, harbored long-standing resentments against each other. However, a few respondents stated that residents were able to set aside these divisions and "put the community first."

The respondents' comments varied in regard to the commitment to community. Approximately half of the respondents said that the same people tend to do everything. One person observed, "I think we certainly have people that are [willing to work on behalf of the community], but it's a small group and it's the same people." The other half of the respondents, however, noted that there are many volunteers. One stated:

> [T]here's really heavy community involvement. I see people working hard to develop community events and community services. I see people advocating for this community much more than they do in a lot of other small communities. . . . There are people here who dedicate significant amounts of time and energy outside of normal jobs. I am very impressed by that.

The people who described the sense of community as being strong said that this had facilitated participation CHIP in several ways. One noted the sense of community was reflected in "excellent turnout" at the community meeting. Others pointed to the commitment of CHIP team members and to the fact that CHIP was perceived as worthwhile by the team members. For example, one person said, "many people stepped forward when asked and recruited because we all . . . thought it was an important thing to work on, even though many of us already had several things to do." And another person stated, "I think it had something to do with the commitment . . . that people showed up and the fact that they kept coming."

The divisions between sub-groups in the community appeared to have little effect on participation in CHIP. One person reported that the divisions between towns within Community A had led to a conflict during one CHIP team meeting. Another believed that the fact that low-income people did not participate in CHIP was a reflection of the divisions between groups based on socioeconomic status. However, a third respondent said that the CHIP process had been beneficial in bridging the barriers between groups, particularly between old-timers and newcomers.

Two people who believed the commitment to community was weak had contradictory opinions concerning how this had influenced participation in CHIP. One person said that the weak commitment to community had not been a hindrance. She noted that many people who usually do not volunteer in community organizations had participated on the CHIP team. In contrast to this statement, the second person reported that the CHIP team members were people who were heavily involved in community efforts. She noted that this contributed to a reluctance to get very involved in CHIP and to feelings of burnout and resentment.

> [T]here might have been those that were reluctant to get overly involved, you know. So I think that might of impacted the process because people were already doing so much. . . . It's not lack of interest in the community. . . . I think that's where, in a small town and a process like this . . . I think that's kind of the drawback of it is that it's a fairly lengthy and heavy process. I don't want to say burning out people, but people, they get tired. . . . I know that I personally just resented . . . you know what I mean . . . because our job required us to be there or . . . not even that . . . you knew that you needed to be there, but you really just wanted to stay home.

Summary

A summary of the respondents' descriptions of the cultural characteristics is presented in Table 10. How each cultural factor was believed to have influenced participation in CHIP is summarized in Table 11.

Table 10
Description of Cultural Characteristics in Community A

Cultural Characteristic	Description
Priority given to health	Some respondents thought health was a low priority due to the economic downturn; others said health was a high priority due to large numbers of retirees and people who are poor. The community is proud of and committed to its hospital. Access to care is the community's primary health concern; few people understand or value health promotion.
Efficacy of collective action	Most respondents said residents believe they have the collective ability to improve the community. However, there is less confidence about making health improvements because they have never tried to improve health and because previous social programs have failed.
Insider *vs.* outsider differentiation	The CHIP coordinator was new to the community and was perceived as an outsider. The CHIP chairperson was also new to the community but was well known and had close ties to other local leaders.
Sense of community/ Commitment to community	The majority of respondents described the sense of community as being strong. However, divisions existed between sub-groups. Half the respondents said the same people do everything; the others said there are many volunteers.

Table 11
Cultural Factors Influencing Participation in CHIP in Community A

Cultural Factor	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Priority given to health	Intangible benefit: CHIP raised awareness of health promotion and led hospital to be more supportive of community health		Extent: Support for hospital led many residents to participate in CHIP Effect: Low interest in health promotion led some team members to view CHIP wellness goals as insignificant	
Collective efficacy	Benefit: Sense of efficacy led team to take on substantial projects Intangible benefit: CHIP built confidence that health improvements were possible and encouraged creative problem solving		Extent: Sense of efficacy contributed to community & team member commitment Extent: Lack of confidence concerning health improvements created urgency to achieve tangible results Effect: Previous program failures led two people to doubt that CHIP projects would succeed	
Insider vs. outsider differentiation				Coordinator being unknown meant process was perceived as unbiased Chairperson's connections to local leaders meant process was perceived as being controlled Coordinator's status as outsider led one team member to distrust her

				Some members trusted the chairperson because he was known
Sense of community; commitment to community	Intangible benefit: CHIP bridged barrier between old-timers and newcomers	One person said divisions between sub-groups led to exclusion of low-income people	Extent: Strong sense of community led to excellent turnout at community meeting and strong commitment of team members Effect: Strong sense of community led team members to view CHIP as worthwhile	One respondent said divisions between towns in Community A resulted in conflict during a team meeting Few people do everything led to burnout and resentment

The Influence of Physical Factors and Social Structure on Participation

In this section, the respondents' descriptions of Community A pertaining to four factors in physical setting and social structure are presented. These factors include (a) physical and structural barriers, (b) civic organization and experience with social planning, (c) leadership, and (d) community resources. The respondents' perceptions of how these factors influenced participation in CHIP are also described and, as in the previous section, a fourth dimension of participation, perception of the process, is included in the analysis.

Physical and Structural Barriers

The barrier mentioned most often in Community A was time constraints. Several respondents said that time constraints made it difficult for the busy, professional people who served on the CHIP team to attend every meeting. Time constraints also served as an impediment to involving youth on the CHIP team, and one respondent said that the decision to hold the CHIP community meeting in the evening meant that few elderly people were able to participate. Other barriers that were mentioned less often included (a) language barriers, which made it difficult to involve the Hispanic community and impeded the ability of the only Hispanic representative to participate in the decision-making process; (b) limited access to or familiarity with e-mail, which hindered communication between team members; (c) distance, which hindered people from the outlying communities from participating in CHIP; and (d) lack of child care, which might have curtailed the involvement of the low-income population. An additional barrier that

was noted through both field observation as well as document review was the limited amount of public transportation. There was one local taxi, but no public bus service.

In addition to the physical and structural barriers that were mentioned, several people described psychological or interpersonal factors that had hindered the participation of the low-income population, the Hispanic community, and youth. These included conflicting personal priorities, not being invited, feeling uncomfortable or intimidated at CHIP meetings, and having concerns that were not shared or understood by the CHIP team members. According to some of the respondents, the limited involvement of these sectors did not affect CHIP because agency personnel advocated on behalf of their interests and concerns. However, one person observed that advocates might not accurately represent these populations. She stated, "yeah, you are representing them . . . you're not them. And I can say what they want—what I think they want is all I can say and what I want them to think they want, you know. It's hard . . . ." Another stated that, if these sectors, particularly the low-income population, had been included, "the goals might be the same, but it would be from a different point of view. . . . Or it would have been a full community [effort]."

Civic Organization and Experience with Social Planning

Civic organization was determined by noting the number and size of voluntary associations. The respondents in Community A reported that this community has many civic groups, church groups, and school-related groups. This finding was supported by a Chamber of Commerce document, which listed 22 churches, 9 major fraternal and service organizations, and several smaller community associations. However, the membership of

these groups tended to be small. A few people said that it was mainly the seniors who participate in these groups. One said that only the middle- or upper-class people participate. Others noted that the same people belong to many of the groups.

This community's experience with health planning prior to CHIP was limited. Most of the people who were interviewed could not recall previous health planning efforts. However, one respondent remembered a community health assessment that was conducted about ten years ago that resulted in a report. Another recalled an effort to promote mental health services that, in her opinion, was positive. A third person remembered a community effort to sustain the hospital that was successful. Although health planning has occurred infrequently, the respondents were aware of several social planning activities related to economic development and a few related to the development of youth programs. When they were asked if these efforts had been successful, some of the respondents said that they had been while others stated that little had been accomplished.

The only association that most respondents saw between their community's civic organization and participation in CHIP was that the CHIP team members were, for the most part, active in other organizations. The team members were described as being "the doers", the people who "historically participate". One person went on to explain that, because the team members were accustomed to serving in voluntary organizations, "they understood that this was a process or it was a limited commitment. They weren't overwhelmed with the commitment." Similarly, another noted, "they're the doers. . . . So I think [this] contributes to the fact that they stuck with their commitment, and they came,

and they did what they were asked to do." Two of the respondents stated that the CHIP team members brought skills to the process that they had gained through their involvement in other voluntary groups. For example, one referred to a team member who had gained experience in grant writing and program development through her work as a volunteer. The other observed that, because of their involvement in voluntary associations, the team members are "all good organizers, they are extremely good organizers." She explained:

> When I said that they do things intuitively, it's still really good stuff. . . . These people could put on a garage sale like you've never seen. Or they could put on an event . . . and they can get all the steps in motion. . . . They are very skilled at that.

According to most of the respondents, the community's history of planning had little or no effect on CHIP. However, two people who recalled previous planning efforts that had been successful noted that this might have contributed to a sense of optimism about the ability of the team to affect change. Conversely, an individual who had mentioned a previous planning failure reported, "I think that [team members] were afraid that it was going to be a process like that. I think they're probably glad that we actually had some tangible results because I don't think that happened with the other project." These comments suggested that the residents' optimism concerning CHIP varied depending upon their perceptions of the community's prior planning experiences.

Leadership

In this community, two categories of leaders were identified: the former leaders and the current leaders. The former leaders were described by some respondents as being the "Founding Fathers," the people who were once effective community leaders but are elderly now and are no longer active. Others, however, referred to them as "good old boys" who have lost much of their power but still have the ability to impede community progress. The current leaders included both the elected officials and the leadership-at-large (influential people from various sectors of the community). The majority of the respondents believed that the elected leadership was weak: that they lacked focus, were unable to work together, and had poor problem-solving skills. In contrast to this negative appraisal, most people said that the leadership-at-large was collaborative, innovative, optimistic, capable of achieving results, appreciative of health as a key component of a strong community, and able to engage others. One respondent, however, described these leaders as manipulative, controlling, and non-inclusive and two people said that the current leaders, in general, lacked commitment.

The CHIP team in Community A included leaders from many sectors of the community but few elected officials. According to most respondents, the strengths of the leaders who participated had facilitated the community's participation in CHIP. They reported that the involvement of these leaders contributed to the members' commitment to CHIP, their confidence in decision-making, the ability to remain focused, the ability to set realistic goals, the potential to attain results, and in the achievement of a satisfying group process. For example, one person noted that the CHIP chairperson was skilled in

"organizing and prioritizing and keeping things contained" and said that, even though CHIP was "pretty loose and can get kind of nebulous, he was able to keep things going forward." She also said that the projects that the CHIP team chose were "realistic and reasonable" because "the leaders were able to keep things from getting too 'pie in the sky.'" Another person commented on the team members' confidence in making decisions and observed, "I never got the sense that there was any hesitation about dealing with a difficult issue. . . . They had pretty strong personalities, not abrasive but just strong personalities. And that helped them. They were able to deal with tough issues." A third respondent said that the leadership of the team members meant that they were "open-minded and creative in their thought process, willing to listen to what people told them and use it in their decision-making."

In contrast to these opinions, a few of the respondents reported that the weaknesses of the local leadership had a negative effect on CHIP. One person said that the lack of commitment that was characteristic of the current leaders was reflected in the CHIP coordinator's decision to resign before the CHIP projects had been implemented. She noted that the coordinator's resignation led to a loss of stability in the team. Another person, who perceived the leaders as being closed and manipulative, said that this had hindered broad-based participation in CHIP. She stated that the leaders' unwillingness to involve others made the process non-inclusive. Also, the behind-the-scenes maneuvering that, in her opinion, took place reinforced a perception that "there are a few people who make the decisions and who are going to say how it is." This assessment was shared, to some extent, by a third respondent who described the close relationship between the

CHIP chairperson and other community leaders who served on the CHIP team as a "mutual admiration society" where "it's the same people that serve on all the committees and they already know kind of what the agenda is." Lastly, a few respondents noted that the presence of "good old boys" who resist change could impede implementation of the CHIP projects.

Resources

The small size and limited number of health and professional resources suggested that this community had few resources to draw upon to support their health development effort. Only three accountants and two attorneys were listed in the phone book. There was one hospital with 49 beds (29 of which were for convalescent care), 10 primary care physicians, no general surgeons, one nursing home, and a satellite office of the county public health department with one full-time nurse.

Despite the fact that community resources were not ample, nearly all of the respondents said that they were sufficient for the planning phase of CHIP. Financial resources were not a problem because the hospital and the ORH provided the funding needed to employ a coordinator and to cover the cost of materials. The leaders who served on the CHIP team as well as the ORH staff provided the necessary professional support. Physical facilities, technical resources, and staff support were also reported to be adequate, although the coordinator and one other respondent stated that additional staff support would have been helpful.

Although the planning phase had not been hindered by a shortage of resources, several respondents stated that limited financial resources could impede implementation

of the CHIP projects. One person stated, "I would say the financial resources are going to be the piece that's going to be the hard one. Because there's just not … a lot of undedicated money." On the other hand, others believed that implementation would not be hampered by lack of funding. Some people noted that the CHIP team members chose projects that were realistic to achieve with existing resources. Others observed that the community had some sources of funding. The hospital, in particular, was viewed as being an important resource for CHIP. The hospital's contribution to support implementation of the CHIP projects was noted by one respondent who said, "I think if [hospital administrator] had not committed the matching $25,000, I would not have given it [much of a chance]. . . . Certainly, the hospital came through."

Another resource that was mentioned by several people in this community was someone to oversee or coordinate the CHIP effort. At the time that this study was conducted, the coordinator had resigned and no one had been hired to replace her. Many respondents expressed concern about whether a capable person could be recruited. A coordinator capable of monitoring and supporting project implementation was viewed as an essential resource by the team members, who said that they were too busy to assume this responsibility themselves.

Summary

A summary of the factors pertaining to the physical setting and social structure is presented in Table 12. How each factor influenced participation in CHIP is summarized in Table 13.

Table 12
Description of Factors Pertaining to Physical Setting and Social Structure in Community A

Physical and Structural Factors	Description
Physical or structural barriers	Barriers included time constraints, language differences, limited access to or familiarity with e-mail, distance, lack of childcare, and lack of transportation. In addition, there were psychological or interpersonal barriers including conflicting personal priorities, not being invited, feeling intimidated at CHIP team meetings, and having concerns that were not shared or understood by CHIP team members.
Civic organization and experience with social planning	There are many voluntary organizations but membership was small and the same people belonged to many of the groups. The community had experience in planning related to economic development but little experience in health planning. Respondents provided mixed assessment of the outcomes of previous planning efforts.
Leadership	There were two groups of leaders: the former leaders and the current leaders. The former leaders were described as respected "Founding Fathers" by some, and as "good old boys" who resist change by others. The current leaders included the elected officials and the leadership-at-large. Most respondents said the elected officials were weak, but the leadership-at-large was strong. However, one person viewed the leadership-at-large as controlling and two people said the current leadership, as a whole, lacked commitment.
Resources	Resources in all categories were sufficient to support the planning phase. Financial resources to support project implementation were limited. Several mentioned the need to hire a new coordinator.

Table 13

Physical and Structural Factors Influencing Participation in CHIP in Community A

Physical and Structural Factors	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Physical or structural barriers	Decision-making: Language barriers hindered involvement of Hispanic community in decision-making; psychological and interpersonal barriers curtailed direct involvement of low-income population in decision-making	Barriers hindered participation of several sectors, including low-income population, Hispanic population, and youth	Extent: Time constraints made it difficult for team members to attend every meeting	Limited access to or familiarity with e-mail impeded communication between team members
Civic organization and experience with social planning	Decision-making: The skills that team members gained through their participation in other voluntary associations were useful in program planning for CHIP		Extent: Team members experience in serving in other voluntary associations contributed to their commitment to CHIP Effect: Residents' optimism concerning CHIP may have been influenced by their perception of previous planning efforts	
Leadership	Benefits: Because the leaders who participated in CHIP were strong, the projects that were planned were likely to be implemented Decision-making: Leadership strengths led to confidence in making decisions Benefits: Presence of "good old boys" could impede implementation of CHIP projects		Extent: Leadership strengths contributed to members' commitment and investment in CHIP	The strengths of the leaders who participated in CHIP helped team to remain focused, produced realistic goals, and led to satisfying group process Lack of commitment among leaders was reflected in CHIP coordinator's decision to resign and led to loss of stability in the CHIP team

				A small group of leaders with close connections led to perception that CHIP was being controlled
Resources	Implementation: The resources contributed by the community, in combination with those contributed by ORH, were sufficient to support the planning phase Benefits: Some respondents worried that implementation would be impeded by lack of funding Benefits: Implementation of projects could be hindered if the community was unable to recruit a competent coordinator			

Additional Findings

This section presents additional factors in the culture or in the physical and social structure of the community that were identified by the respondents as having facilitated or hindered participation in CHIP.

Positive Perception of Hospital

In this community, several respondents observed that the residents had a favorable perception of their hospital, and they noted that the fact that CHIP was associated in the public's mind with the hospital had a positive effect on participation. Being associated with the hospital meant that CHIP was, and will continue to be, viewed by the residents as important. As one person explained, "So, clearly … [the hospital's involvement is] going to continue to lend itself towards, 'well, if the hospital's behind it, then it's a good thing.'"

Small Size

The small size of this community was reported to have had both a positive and a negative effect on participation in CHIP. Small size was perceived as an asset because it contributed to greater familiarity. One person stated that, because the community is small, the CHIP team members had connections with the residents, which allowed them to understand their needs and inform them about health:

> I do think that one of the strong points [of rurality] is . . . the connection. . . . You go to the local stores or you go to your church or your club or whatever, and you know a lot more people than you would if you were living in the city. . . . And if they know you at all or have any respect for

> you, then they . . . will listen to you. . . . And you can listen to them . . . and understand what their needs are.

Another stated that the team members' familiarity with one another contributed to a sense of trust:

> [Team members] knew one another. They either knew them personally, or by reputation . . . they had some credibility. I think that's the other thing [about] a small town. . . . Because you know the people involved . . . you've worked with them before, you know who to trust and who not to trust, who to believe and who not to believe. . . . I mean, I trusted [the chairperson].

It was also noted that community health assessment was easier and planning was potentially more effective because the community was small:

> [I]t's easier and perhaps more effective and more feasible because it's smaller and you have folks coming together who . . . maybe have more knowledge and maybe have a better assessment because it isn't so . . . I mean it is complex, but it's not Chicago.

On the other hand, the small size of the community meant that the team members had no anonymity. One respondent explained that, because everyone knew each other, they could not say what they thought without running the risk of offending an associate or opening themselves to an attack. The effect this had on CHIP was to reduce honesty during the discussions:

> Some of us felt like we couldn't say what we really felt about a project or an idea or something because we have to work with everybody all the time. And there were a couple times where . . . you went along with something that maybe, if you were totally clean from anything, you might have said "I call bullshit on that. No! That's a waste of time." But you couldn't because of the person involved. That's the thing that I think is the hardest part about this process in a small community, is the inability to maybe be as frank about things....

Similarly, another person reported that the small size of the community led to greater vulnerability for at least some of the participants. She explained that, when people work together in a small community, there is risk involved because "when there's one mental health counselor in town, it's sort of much easier to make it personal..." and the team "becomes more individuals dealing with individuals, [rather] than agencies dealing with agencies." This was contrasted with the experience of working in a large community where "there's a good deal of protection there and there's a good deal of agency."

The Presence of Newcomers

In this community, the concept of old-timer vs. newcomer emerged as a factor that influenced participation in CHIP. One respondent described the presence of old-timers as being a hindrance to community health development. She stated:

> [T]he people who have lived here all their lives—50, 60 years, maybe longer—and have not . . . lived in some other place . . . they really aren't

> aware of . . . activities and other things that perhaps could be done to make things a little better in the community. And, you know, they've always gotten along this way so . . . why do you come in here with these fancy ideas?

Conversely, another person said that newcomers were an asset because they came with new ideas and with enthusiasm.

> There are a lot of people here who've never lived anywhere else. . . . So they know nothing else. But we [also] have a lot who have moved here from large cities. . . . And when you come from outside . . . like, when I came from [a large city], I saw the benefits that people who have lived here all their lives don't see. . . . And so I think, because of that, there's a lot of enthusiasm for the area. And so they have the experience of the big city and what kind of health care, say, was there, what was available. And . . . they bring that into play too.

These respondents had lived in the community for 14 years and 24 years, respectively, and yet appear to perceive themselves as newcomers. In contrast to their comments, one person who had lived in the community her entire life expressed frustration with the attitudes of newcomers. She stated:

> You get these people that come from California and why they pick [Community A], I have yet to figure out. Because then they complain royally, "well you don't have this like I did in California" or "you don't

have the coverage like I did in California." And you almost want to say, "Go back to California! Why did you come here?!"

None of the respondents who noted that the old-timers were resistant to change believed that this had hindered CHIP. One person said that the fact that CHIP was well received suggested that the old-timers were more receptive now than they had been in the past and that they recognized that health improvements were needed. Another reported:

> [I]t would come up where people would not be open to the new ideas or changes. But I don't think it stopped the group from going forward. . . . And, if you look at what we . . . came up with were programs that were really modeled after other communities. And I think that . . . shows that we didn't get stuck with, "well, we've [always] done it that way."

She and others attributed the creativity of the outcomes to the presence of newcomers on the CHIP team. Also, as previously reported in this chapter, one respondent believed that CHIP had been beneficial in bridging the gap between old-timers and newcomers in this community. None of the respondents who expressed resentment toward newcomers spoke about how the presence of newcomers had affected participation in CHIP.

Perception of Being Disenfranchised

A few of the respondents described the community as disenfranchised, as the "armpit of Oregon" or the "bastard child" of the county. This perception was partially linked to isolation. As one person explained, "there isn't anybody else around. I mean, we are the town." It was also associated with the depressed economy. ("We can't get a store where you can buy underwear and socks on a consistent basis.") In addition, county

decisions, such as the decision to develop a large low-income housing project in Community A, were another reason the residents felt as if they had been "done to."

One person noted that, because they feel disenfranchised, the residents were willing to participate in problem-solving efforts. She stated:

> You know, we're just kind of mad as hell and we're not going to take it anymore. So, if there's an issue that comes up that people find passion in, you can rally that group to kind of take care of it.

This respondent suggested that the frustration of being disenfranchised contributed to the high level of community involvement in CHIP. Likewise, another person said that the perception of being disenfranchised has pulled the community together and, in turn, facilitated participation in CHIP. On the other hand, one individual who described the community as disenfranchised said that the health problems in the community were "bigger than I know how to fix".

Avoidance of Competition and Conflict

The coordinator, who had recently moved to Community A from an urban area, remarked on the absence of competition among the CHIP team members. She said:

> I think that the people were gentler with each other and polite. I think, in an urban area, there probably would have been more overt competition and fighting for . . . dollars, less cooperation and less willingness, maybe, to work together just because there might have been more dollars to be going for. Here, there are so few resources . . . but also there's just a politeness. People don't like conflict as much in a rural area.

The absence of conflict might be associated with the lack of anonymity that was discussed above.

According to the coordinator, the desire to avoid conflict was reflected in the fact that the CHIP team members were cooperative, even generous, when decisions were made to allocate funds to the CHIP projects. For example, she noted that two sub-committees chose to withdraw their requests for money so that the funds could be allocated to other programs. She also stated that the team members were tactful and non-confrontational when dealing with personnel from agencies who, in their opinion, were not performing satisfactorily. Another respondent also noted that the team members did not compete for funds. However, later in the interview, she said that the reason so many of the team members agreed to participate in the implementation task force was because they did not trust each other and wanted to assure that their part of the budget was used for the intended purpose.

Summary

In addition to the characteristics they were questioned about, the respondents mentioned five other community characteristics that may have had an influence on participation in CHIP. Table 14 summarizes the findings that were reported in this section.

Table 14

Factors Outside of the Conceptual Model That Influenced Participation in Community A

Community Characteristic	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Positive perception of hospital			Effect: CHIP's association with hospital meant that CHIP was perceived as valuable	
Small size	Decision-making: Team members were aware of residents' needs Decision-making: Community assessment was easier because community was small Decision-making: Potential impairment in decision-making due to reduced honesty and openness		Form: Small size meant lack of anonymity which contributed to discomfort in voicing opinions Form: Small size increased member vulnerability	Team members' familiarity with community residents meant that they were able to inform them about health Team members' familiarity with each other contributed to a sense of trust
The presence of newcomers	Benefits: The presence of newcomers on CHIP team contributed to creativity of outcomes Intangible benefit: CHIP bridged gap between old-timers and newcomers			

Perception of being disenfranchised			Extent: Perception of being disenfranchised prompted community members to participate in CHIP Effect: One person who perceived that community was disenfranchised was discouraged about potential to resolve problems	
Avoidance of competition and conflict				Tendency to avoid conflict meant that team members were non-confrontational and did not compete for CHIP funds; one person said that conflict was exhibited in indirect ways

CHAPTER VI

CASE DESCRIPTION OF COMMUNITY B

This chapter describes Community B and its participation in CHIP. Like the previous chapter, it begins with an overview of the community and its stage of involvement in CHIP. The pattern of participation is presented next, followed by a description of the respondents' views concerning selected cultural, physical, and structural characteristics and their influence on CHIP. Finally, additional community characteristics that facilitated or hindered participation in CHIP are described.

Community B Description

Community B encompassed a large portion of a county in eastern Oregon. As in the case of Community A, its boundaries were established to correspond to the service area of the local hospital. There are 19 communities that were included in Community B, although several of these were not towns per se, but were places identified by a zip code. The population of Community B had been growing. In 2002, it was 14,266, which was up from 12,711 in 1990 (Office of Rural Health, 2003). The largest town (which will be referred to as Town B1) had 9840 residents and was the county seat. It was located 50 miles from the nearest larger community (population 12,450) and 129 miles from a city with at least 50,000 people. A major interstate highway traversed Town B1; however travel in either direction required crossing mountain passes that received snow during the winter months. Most of the roads that linked the smaller towns in the county to Town B1

and to each other were single-lane. Many of these followed rivers or passed through mountains, and some were unpaved. Travel between communities tended to be slow.

The residents of Community B were, on average, older, poorer, and less educated than their statewide counterparts (see Table 15). Slightly more than 16% of the working population was employed in education, health care, or social services (U.S. Census, 2000). The second highest source of employment, at 14.4%, was agriculture, forestry, fishing and hunting, and mining. Town B1 had four businesses that employed more than 200 people. These were, in order of number of employees, the school district, the hospital, a forest products manufacturing business, and the U.S. Forest Service. Although the area had experienced a decline in logging, new jobs had been created in forest products manufacturing. Agriculture was a major industry in the communities outside of Town B1.

Table 15
Selected Demographic Characteristics of Community B as Compared to Oregon[1]

Demographic Characteristic	Community B	Oregon
Median Age	45 years	40.0 years
Percent Below Poverty	14.4%	11.6%
Median Household Income	$31,391	$37,938
% Population Age 25+ Without High School Diploma	20%	14.9%
Average Unemployment Rate	8.8%[2]	6.3%

Note. [1]ORH, 2003. [2]This figure reflects unemployment rate for the entire county, not Community B.

Community B became involved in CHIP in the summer of 2001. The Commission on Children and Families, a department within the county government, served as the sponsoring agency for the local initiative. Sixteen people participated in the

team, which met from September 2001 until June 2002. Two additional members joined in January 2002. At the time of this study, in the fall of 2003, the CHIP team was still an active group. Full team and sub-committee meetings were being held regularly and substantial progress had been made in implementing the proposed projects. However, the composition of the team had changed. Rather than representing a wide range of towns and sectors within the region, all but one of the current team members were health care professionals, mainly hospital employees, from Town B1.

How Participation Was Enacted

Cohen and Uphoff's (1980) framework for participation was used as a guide for developing this case study description of community participation in CHIP. Table 16 presents a summary of Community B's pattern of participation based on each of the dimensions in this framework.

Table 16
Dimensions of Community Participation in CHIP in Community B

Dimension of Participation	Description
What Kind of Participation Occurred	
Participation in Decision-Making	There was broad-based community involvement in identifying needs but the participation of non-health sectors diminished when strategies were chosen and was lost after the planning phase ended. The health professionals who served on the team believed all were comfortable with decision-making, but the respondents who represented non-health sectors expressed discomfort.
Participation in Implementation	The hospital, the county, and other organizations and citizens furnished money, space, equipment/supplies, and labor. After the planning phase ended, team members and other residents volunteered their time to implement the projects. Funding was sought from outside the community.
Participation in Benefits	Several projects were planned and grant funding was received. Two projects had been implemented and two more were about to begin. Intangible benefits included: greater awareness of health matters; increased awareness of resources to support hospital; and the public had an opportunity to express their concerns, thus decreasing dissatisfaction with local health services.

Who Participated	The CHIP team was predominately White, middle-aged, female. Members represented a cross-section of economic interests, human services, and geographic regions; 38% represented the health sector. Few leaders participated. Retired people, youth, government officials, low-income people, and members of ethnic minority populations were not on the team.
How did Participation Occur	
The Basis of Participation	ORH invited Community B hospital to participate. Hospital became involved because CHIP is consistent with mission, was a resource to them, and had potential to improve their relationship with community. Commission on Children & Families served as sponsoring agency because CHIP complemented their role.
The Form of Participation	Aim was to recruit people from diverse community sectors; a secondary goal might have been have high representation from the remote regions of the county. Elderly, youth, and low-income people were represented by advocates and agency personnel.
The Extent of Participation	Time commitment was described as heavy but none said it was overwhelming. Attendance was sporadic and attrition occurred. All but one of the members representing non-health sectors dropped out of CHIP when planning phase ended. Community B remained committed to CHIP but the team was now dominated by health care professionals.
The Effect of Participation	The initial perception of CHIP was very positive. Residents had a desire to see the health system improve and appreciated the opportunity to voice their opinions. For the community-at-large, the excitement faded over time and few would know that CHIP was continuing. However, members of the health care community believed CHIP was important.

What Kind of Participation?

This section describes participation in decision-making, participation in implementation, and participation in benefits.

Participation in decision-making. The Community B CHIP team adhered to the process for decision-making that is described in Chapter 4. The team members reviewed statistical reports provided by the ORH and conducted individual and group interviews to ascertain residents' perceptions of the community's health needs and the adequacy of

local health services. Nearly 70 people were interviewed and approximately 100 individuals from throughout the county participated in the community meeting. After reviewing the quantitative and qualitative findings, the CHIP team members followed a structured process to identify priority health concerns and then, working independently in sub-committees, decided on strategies for addressing these. In addition, the team members decided how to divide the grant from the ORH among the projects that were proposed. After the official planning phase ended, the team members continued to work together in an effort to implement the projects. From this point forward, they held the responsibility for organizing the meetings and maintaining the process. The ORH staff member no longer participated in the CHIP meetings; however the ORH did continue to support the team's work by providing a second grant.

Most of the respondents believed that the community had control over decision-making. Although two people noted that the CHIP team received guidance from an ORH staff member in how to make decisions, they and all of the other respondents agreed that their choices were not in any way influenced by the ORH. In addition, it was noted that people from many community sectors and geographic areas participated in the CHIP team, that a large number of residents attended the public meeting, and that the priority health concerns were chosen on the basis of input received during the public meeting. Two respondents who are health care managers also pointed out that they and other health care professionals had intentionally avoided taking a leadership role in CHIP so that the members who represented non-health sectors would have decision-making authority. One stated:

> We wanted to make sure that the hospital . . . we were just a partner in this. And so we really wanted to make sure that directives or ideas, you know, were shared with the community. There were probably about ten to twelve . . . different organizations involved in our county. . . . We tried to get a representative from . . . school, from insurance, we actually had a real estate agent, we had a minister, we had senior services, we had mental health . . . just every aspect that you could think of. . . . So that was the whole idea. We didn't want it to seem like ours at all. And we didn't want to set the agenda.

However, one of the respondents said that the involvement of the community-at-large in decision-making diminished after the CHIP team split into sub-committees. She noted that the participation of team members who represented the non-health sectors became infrequent at this time and that, in at least one sub-committee, the focus on community concerns was lost. Others concurred that that there was less involvement from the community-at-large over time, and several people mentioned that non-health sectors are no longer participating in the CHIP team.

Comments varied about whether the team members had been comfortable in making decisions. Those who were affiliated with the health care community stated that the team members had been comfortable with this responsibility. This perception was shared by the coordinator who noted that even the team members who did not have a background in health care were active participants in problem-solving:

> I think they really did [feel comfortable]. ... I'm thinking of a lot of [team member], who is in retail lumber. And he was on this committee for health care access and ER. And I was just impressed with his determination to find a solution. . . . He didn't have a background in that, but he was right in there!

However, the two respondents who had represented non-health sectors on the team indicated that they had been uncomfortable during the team meetings. One stated:

> I'm not in the hospital health arena and so I lent what I could as far as the overall to the group. But I didn't feel like I lent enough. And I felt like there's more people that were knowledgeable about it that could do a better job than I.

The other said:

> I wasn't at every meeting but, when I did come to the meetings, I never really felt a part. They were professionals in the medical field and . . . I don't know if it was because I didn't speak their lingo or what it was, but . . . there wasn't the participation I guess. Or even bringing up to speed or explaining. And I think they were doing some things . . . [but] I struggled just a little bit thinking this wasn't what I thought was going to be an end result of this.

Participation in implementation. As is true for all communities that participate in CHIP, Community B was required to provide half of the salary for the coordinator, office and meeting space, and supplies. In this community, the hospital and the county

contributed equally to the coordinator's salary. The coordinator used an office located in her family's business and furnished her own office supplies and equipment. She was compensated for this through her salary. Several organizations in Town B1 allowed the CHIP team to use their meeting rooms, although most meetings were held at a church. The community also provided manpower to support the planning process. Most of the individuals who participated in CHIP did so on a voluntary basis and were not paid.

The office, equipment, and supplies available to the coordinator were adequate. These were located in the coordinator's hometown, a small community located about 40 miles from Town B1. Although the office was basic, the coordinator appreciated its convenience. Internet access and a fax machine were available to her. Most of her communications with CHIP team members and others occurred via email. The church where most of the team meetings were held was located in Town B1. The meeting room was spacious, comfortable, accessible to wheelchairs, and was equipped with a blackboard and modern audiovisual equipment. Parking was convenient and ample. Coffee and restrooms were available.

In the time since the planning phase ended, the community has continued to contribute resources to CHIP. Team members, as well as other area residents with specialized training, have volunteered their time to write grants or participate in implementing the projects. However, funding has been sought from outside of the community.

Participation in benefits. As a result of their participation in CHIP, Community B established several goals to improve the community's health status and local health care

system. These were (a) obtain a Federally-Qualified Health Clinic or a Rural Health Clinic; (b) form a cancer support group, educate health professionals and patients concerning cancer prevention and treatment, and develop a cancer treatment center; (c) host a community forum on health insurance options; (d) develop activities to empower youth and reduce substance abuse; and (e) promote exercise. At the time of this study, several of these goals had been achieved or were about to be implemented. The community had received approval for a Rural Health Clinic, a breast cancer support group had been organized and had several participants, a community-wide health promotion event to encourage exercise was about to be launched, and plans had been laid for a public forum on health insurance options. In addition, $110,000 in grant funding had been obtained to support these projects.

It was also noted that several intangible benefits had been accrued as a result of the community's participation in CHIP. One respondent said that local leaders became aware of resources that were available to support the hospital. Another stated that the community's awareness of health matters was expanded. A third person reported that CHIP gave residents an opportunity to express their concerns about the health care system directly to hospital administrators and physicians and, as a result, dissatisfaction with local health services had decreased.

Who Participated?

The original CHIP partnership team consisted of sixteen members. Eleven (69%) of the members were women and five (31%) were men. Ten (63%) were between 40 to 59 years of age, and two each (13%) were in their 20s, 30s, and 60s. None of the team

members represented an ethnic minority population, although the coordinator noted that one man might have been Hispanic. Table 17 shows the constituencies or organizations represented by team members. Six (38%) of the team members resided outside of Town B1 and so, in addition to representing a particular sector, they also represented the remote regions of the county.

Table 17
Constituencies Represented by CHIP Team Members in Community B

Constituency or organization represented	Number of members
Health care	6
Business	3
Agriculture	1
Seniors	1
Faith (one also represented low-income people)	2
Education	2
Low-income families	1

Others who participated in the team meetings were the CHIP coordinator and one, or sometimes two, ORH staff members. The CHIP coordinator was a middle-aged Caucasian female. She primarily represented the outlying communities in the county and the agricultural sector. The ORH staff members represented their organization, which was located in a large metropolitan area outside of this county.

Hispanic residents accounted for 2.5% of the population in Community B, with other ethnic minority groups being less than 1% (Office of Rural Health, 2003). Slightly over 18% of the population in the CHIP service area was 65 years of age or older and nearly 27% was age 19 or younger. Thirty-one percent of the residents reside outside of Town B1. Thus, when the composition of the CHIP team was compared to the

community as a whole, it was apparent that seniors, youth, men, and the Hispanic population were under-represented on the team, whereas the outlying communities were slightly over-represented.

Most of the respondents believed that the CHIP team reflected the diversity of the community. Several people commented on the breadth of representation from various economic sectors and geographic regions. Some noted that the team lacked ethnic diversity but said that this was also true of their community. A few people mentioned that youth and retirees were missing; others observed that elected officials and other city leaders were not included.

The membership of the CHIP team changed significantly after the planning phase ended. With the exception of the coordinator, all of the individuals representing non-health sectors of the community dropped out. At the same time, several health care professionals, mainly from the hospital, joined the team. Some of the respondents explained that the people who are currently involved in CHIP are those who understand or have a vested interest in health care.

How Did Participation Occur?

This section describes the basis of participation, the form of participation, the extent of participation, and the effect of participation.

The basis of participation. In Community B, the impetus to participate in CHIP came from the ORH. An ORH staff member learned that the Community B hospital administrators were seeking public input, and he suggested to them that CHIP might be a tool for achieving this. The hospital's management team agreed to support the initiative,

but chose not to serve as the sponsoring agency. This was because the hospital, a church-owned organization, did not want to be financially accountable for CHIP funds. Also, the hospital managers recognized that community's relationship with the hospital was not strong and they believed CHIP would be more successful if it was not associated with the hospital (personal communication, P. McGinnis, March 5, 2004). The Commission on Children and Families, a county department, accepted the invitation to function as the sponsoring agency. However, both the hospital and the county contributed the funds needed to support the CHIP coordinator's salary.

The director of the Commission on Children and Families said that her agency supported CHIP because the community assessment that is part of the CHIP process complemented their role and allowed them to hear from sectors of the population they had not previously reached. According to a hospital employee, the hospital chose to support CHIP because: "our . . . slogan . . . is 'helping build healthier communities'. . . . And so we just want to make sure that we're involved in any aspect like that. The focus totally fits our mission." However, another respondent said that the hospital was "hoping to improve their relationship with the community" and a third person explained that the hospital viewed CHIP as a resource in their struggle to survive.

The form of participation. The CHIP coordinator followed the ORH recommendations in recruiting team members from diverse community sectors. However, she noted that because her connections were mainly with people who live in the outlying communities or who work in agricultural settings, she requested and received permission to invite them. Although not directly stated, the coordinator might

have also been seeking to have a high percentage of representation from the remote regions of the county. Later in the interview she said that the health providers in Town B1 often overlook the outlying communities and that her goal has been to assure that the remote regions have a voice in CHIP:

> I'm thinking that the health care people are pretty much involved in their own little community . . . and [are] not really seeing our community. I don't really know . . . [it's] just an unfamiliarity. . . . And I have to keep reminding them of what we do out here, and that we are a community too. And we're our own community, not just part of theirs or leftover from [Town B1]. . . . And sometimes I think they forget about us. . . . I don't think that made a big difference [during the CHIP planning phase] because we did have so many people [from the outlying communities] that were participating at that time. . . . And so [now that I am the only team member from outside of Town B1] I just feel a real need to keep our voice in the process.

In this community, several sectors did not participate directly in the CHIP team but were represented by advocates and employees of social service agencies or schools. These included the elderly (i.e., retired people), youth, and the low-income population.

The extent of participation. The CHIP team met eleven times during ten months. Records of attendance were not kept for many of the meetings; however, the coordinator provided an estimate of attendance. Based upon this estimate, it was noted that none of the members attended every meeting, six attended eight or nine meetings, and ten

attended seven or fewer meetings. In addition to being asked to participate in team meetings, members were asked to attend the community meeting and sub-committee meetings, and to conduct several key informant interviews.

The time that members contributed to CHIP was described by several of the respondents as being heavy, but none suggested that it had been overwhelming. For example, one stated, "The first part of it was slightly labor-intensive, not totally." Another said:

> We met every month, and then we formed sub-groups, and they had separate meetings. . . . There was a lot more initial commitment from [when] it started in June to December, to get questionnaires done and get going on the community ideas . . . interviewing . . . summarize that up. So it wasn't too bad, but then it just depended. . . . I think a lot of people put in a lot of time with the sub-groups. I don't know what's a lot, but a lot. . . . I don't think they felt overwhelmed.

A few people stated that the commitment was quite strong and attendance was good. However, most of the respondents observed that attendance was "hit and miss" and that significant attrition had occurred. One person noted that only the health professionals remained committed:

> As time went on, after the big push for . . . information, then the numbers dwindled by half or a third as meetings continued. And the process only lasted a year basically and . . . people just didn't participate. And you saw the numbers around the table were the medical people who have a vested

> interest in the health care community. . . . So, as time has gone on . . . whether people thought the time commitment was too much or other priorities consumed their time, priorities changed.

As mentioned, all of the team members who represented non-health sectors, except for the coordinator, dropped out of CHIP when the planning phase ended. The coordinator explained that they believed they had fulfilled their obligation: "They put in their one year that we asked them for and now they are thinking, 'well, it's someone else's turn.'" Despite the loss of these members, the community, overall, has remained committed to the CHIP process. Several hospital employees have joined the team and the group has continued to meet regularly.

The effect of participation. Most of the people said that the community's perception of CHIP was, initially, very positive. Residents had a desire to see the local health system improve and they appreciated having an opportunity to express their opinions concerning the services that were needed. One person explained that it was "great to have a chance for the community to say something and have a say in our own health care and have an opportunity to give our opinions." Another observed:

> You know, it was very exciting. I think that [the CHIP team members] were excited. We have an opportunity to give feedback, to maybe get some funds to maybe begin some things. And it was kind of a dreaming opportunity of, if we had an opportunity, this is what we'd like to see happen . . . prioritizing. I think there was a real excitement initially in that.

But whether the community-at-large would, at this time, view CHIP as being worthwhile was uncertain. Some of the respondents noted that there has been little communication concerning CHIP, so most residents would be unaware of what had been accomplished or that the team was still meeting. Others observed that the excitement that had been present when CHIP began had faded over time:

> [The community meeting] was exciting because it was a good turn out. I mean, there was just a buzz in the room. Everyone was participating. I didn't see anyone sitting at a table with their arms folded like I don't know why I'm here. But then, it kind of dwindled as it worked its way down. That was kind of a disappointment to me.

A few respondents noted that within the health care community CHIP is still perceived as being important. A physician who served on the team, said "The CHIP process itself was to last a year. But we felt like it was important enough and there was good enough community support, that we continued it after that time." Another person, who is affiliated with the hospital, spoke of the hospital employees' continuing interest in CHIP:

> I have not run into anybody that doesn't think it's been worthwhile. Yeah, it's a big deal. . . . You know, I was at the hospital two days ago, and as far as getting ourselves revved up for the next big project. . . . I mean, we've moved up to step two; we're past this, moving on to other things. And I talked to three different people while [I was]x there . . . about CHIP. [They said] "well, we gotta", "what about this", "looks like we're getting

> a little bit slow here", and "we need to fire this up". You know, that's not the kind of comments you get from people who aren't bought in.

Cultural Characteristics and Their Influence on Participation

In this section, the respondents' descriptions of their community relevant to the four cultural factors that are part of the conceptual framework are presented. The section also includes a description of how the respondents perceived these factors as influencing participation in CHIP.

Priority Given to Health

The respondents were divided in their assessment of how this community ranks health in comparison to other local needs. A few people explained that health is not something that many residents think about and that, "until there's a crisis that develops in some way, [health will not] grab their attention". But others noted that health services are very important for attracting people to the community, and especially for attracting retirees. One person observed that, as the population of Community B has become older and people have required more medical care, there has been a growing concern about the quality of local health services. Later, he stated that the hospital in Community B does not have a good reputation among the residents, noting that "for every one good story, there's always five bad ones." The hospital's poor reputation in the community was mentioned by other respondents as well. One person stated that "there is a perception that many of our physicians, one, are reluctant to refer out. . . . And, two, that if you have anything serious, for God's sake, go somewhere else. Don't go here to the hospital."

Most of the respondents mentioned limited access to care due to an inadequate number of providers, high cost, and insufficient insurance coverage as the community's primary health concerns. A few said that aging and chronic disease were among the community's top concerns. One person stated that alcohol, tobacco, and drug use was of high concern in this community.

The respondents who believed that the community was concerned about health said that this facilitated participation in CHIP. One person stated, "people just realize it's a huge issue. So I think that's why they are like, 'sure, I'll be on that committee'. It didn't seem hard to recruit." Another explained that community members participated because they were concerned about health care costs and insufficient or insecure health insurance coverage. Similarly, a third person said that "a desire to see the [local] system improve" motivated many people to join the CHIP team.

On the other hand, those who believed that health was a low priority for the community in general said that this was why attrition was high among the members who represented the non-health sectors. They pointed out that the CHIP team currently consisted almost exclusively of health professionals who, unlike the community-at-large, were interested in health issues. However, one individual stated that CHIP was beneficial in raising awareness of health among community members.

Perceived Efficacy of Collective Action

The majority of the respondents stated that at least some, if not most, of the residents were optimistic about their collective ability to improve the community. Some people observed that Community B has a history of accomplishment. They pointed to the

development of the downtown historic district, a sports complex, and a tourist attraction as evidence of the residents' willingness to work together to bring about positive change. One individual noted that, because the community was land-based and isolated, the residents were resilient and self-reliant.

> What I think makes a difference here is there is a history and an ability to do things that comes from living close to the land. There's a resilience here. . . . We have the advantage of being far enough away from others that . . . we have a physical sense to help us understand our isolation. . . . We're far enough away from everybody, there's more of a . . . living, functioning community that works together. . . . You've got a history of solving our own problems . . . you're just not sitting there looking for someone to solve the problems because, you know . . .we're out here in all this ground and . . . there ain't no cavalry, there's no cavalry. We just got to figure out what to do.

A few people noted that the community was divided between those who believe that change was possible and those who were less optimistic. It was noted that there was a group of people, the "movers and shakers," who were positive about change and were active in the community. At the same time, was also a group of residents who either felt overwhelmed by the complexity of the problems or had an attitude of "I'm not going to do that; we've tried that for 40 years and it's not gonna work, so why should I?"

Only one person was completely negative in her description of the community's collective efficacy. She stated that, unless they had a cheerleader, the residents of Community B were not motivated to improve the community.

One respondent said that the fact that people in her small hometown were able to successfully develop a medical clinic was proof of their confidence. However, others were more tentative. Two people drew attention to the magnitude and complexity of the rural health care crisis yet, at the same time, noted that the residents were willing to try to make a difference.

> [Rural areas are] the tail of the dog, if that much – probably a hair on the tail of the dog [in regard to the national health care system]. … You know, a lot of times in urban areas, you get people [who] just lay over and whine. And people here, well, they're used to "okay, well yeah, bad things happen; let's deal with it."

Similarly, another respondent said that "some people . . . feel a little helpless . . . and kind of don't want to try anymore. But, for the most part, people are willing to . . . try to get [the health system] improved." She also commented that she perceived the residents as being more confident about influencing health than they were about influencing other community concerns, such as the economy.

The people who reported a fairly high level of optimism about collective actions believed that this had facilitated participation in CHIP. Several people said that the willingness of residents to participate, as well as their willingness to remain committed after the planning phase ended, was due to their belief that they could make a difference.

One respondent said, "people wouldn't have come if they didn't think they could do something" and another noted, "I think it was [because of the optimism] that CHIP … continued on. And it didn't peter off." A third individual stated that the team members' confidence in their ability to bring about change led them to seek solutions to problems that, in her opinion, were very complex and challenging. Still others reported that because the residents are self-reliant, they appreciated having an opportunity to be involved in improving health and found the CHIP process to be important and exciting.

On the other hand, the individual who believed that residents lack motivation to make change unless they have a cheerleader said that this had a negative effect on CHIP. In her opinion, CHIP lacked a cheerleader and, as a result, many of the team members, particularly from the non-health sectors, became distracted, lost interest and eventually dropped out of the team.

Insider vs. Outsider Differentiation

The CHIP coordinator was the person who was most frequently identified as the leader of CHIP in Community B. However, two of the respondents identified an employee of the hospital as being the CHIP leader or co-leader, and one person did not think that anyone had been the leader of CHIP. He believed that all of the team members contributed equally to the process.

The coordinator resided in a small agricultural community located 40 miles from Town B1. Although she and her husband had lived in this community for 20 years and owned a business, the coordinator doubted that they would be considered insiders because their family roots were not in this area. Nevertheless, she and others stated that

she was widely known and respected in the outlying regions of the county. The coordinator was not, however, known to residents of Town B1 except to people employed in agriculture. The hospital employee who was identified as being the leader or co-leader by two of the respondents was well known in Town B1.

Most of the people who were interviewed said that the coordinator's familiarity to people living in the outlying regions of the county had facilitated participation in CHIP. They noted that her connections to ranchers and others from the smaller communities enabled her to recruit people from a variety of geographic areas to the CHIP team. Another respondent who described CHIP as having two leaders—the coordinator and the hospital employee—also observed that familiarity had been beneficial. She said that credibility was associated with familiarity; therefore it was advantageous to have two leaders who were known to different groups of residents.

On the other hand, one respondent thought that familiarity had the potential to bias a planning process. He stated that the fact that the coordinator was not known in Town B1 had facilitated participation in CHIP:

> There are definitely very strong leaders who have been in leadership positions . . . forever in Community B and they weren't part of the process. And that may have been a good thing. . . . [The problem with those] that have been around forever is that everybody knows what they think. . . . And so there wasn't any bias brought into the deal that there was going to be a slant on the project because of who was involved. And the people that were involved are pretty independent people and

> independently minded. And I think that that was one of the other things that [coordinator] did a good job . . . in terms of selecting, because I think some of the other folks might not have only dominated the process, but . . . we may not have has as good of community support because it would have been, "well, of course, this is what they're going to do."

Two of the respondents disagreed with this statement. In their opinion, the coordinator's unfamiliarity in Town B1 had hindered participation in CHIP. One said that the coordinator did not have the relationships with key people and groups that were necessary for promoting the initiative. Another suggested that the coordinator's lack of familiarity may have reduced trust and impeded communication with CHIP members, and thus slowed the process.

Sense of Community and Commitment to Community

All of the respondents agreed that the sense of community is strong in Community B. Whether describing Town B1 or one of the small outlying towns, everyone who was interviewed said that residents knew their neighbors and valued their community. At the same time, it was noted that divisions existed within Community B. The most frequently mentioned division was that which existed between the outlying towns and Town B1. This was attributed to distance and different lifestyles. One person observed that "there's almost a different culture in some of those towns." Because of this, residents of the small towns did not feel connected to Town B1. In addition, two of the respondents reported a division between long-term residents and the retirees who had moved to the area.

The commitment to community was generally described as being strong as well. This was particularly true in the outlying towns where it was noted that residents were very willing to work on behalf of their community. In regard to Town B1, several people reported that there were many residents who are willing to donate their time or resources to the community. However, a few respondents observed that there was a segment of the population that was unwilling or unable to contribute to the community because of personal crises and poverty and one person reported that, in Town B1, a few people did all of the work. Two respondents provided contradictory statements, saying there were a large number of people who were willing to commit their time while also stating that "only a handful" did everything or that residents were unwilling to "volunteer for more than once or twice a year."

Most of the people who were interviewed believed that the strong sense of community had a positive influence on participation in CHIP. Some noted that the diversity of people who participated and the fact that they weren't those who typically get involved was a reflection of the sense of community. Others said that the strong sense of community provided the incentive for people to become involved and to view CHIP as being important. For example, the coordinator stated:

> Each of the people that I talked to . . . were really interested in helping out. They said, "oh, this is really important." And I knew they didn't have a lot of time to spend, but they were willing to do it because our community needed it.

Another person said that the sense of community contributed to the team members' commitment to find a solution to the local health crisis:

> I think a lot of people in the group were surprised by the potential crisis in terms of health care. And once that was discussed and made evident . . . I think there was a strong sense of ownership and that we needed to do something to make things better. And a willingness to commit to the process.

The divisions that existed between the outlying communities and Town B1 were not thought to have hindered participation in CHIP during the planning phase. However, the coordinator, who was the only remaining representative from the outlying towns on the current CHIP team, expressed a fear that the outlying towns would be overlooked as the CHIP projects were implemented.

> I don't think that [divisions between communities] made a big difference at that time because we did have so many people [from the outlying towns] that were participating at that time. . . . And so [now that I am the only team member from outside Town B1] I just feel a real need to keep our voice in the process. And maybe that's all we need to do is keep letting [Town B1] know that we're out here. [Q: "So that as services are developed and so on, that they'll make sure they reach you?"] Yeah. And like activities, hopefully, are not just for the [Town B1] people, or the people that can go to the health clubs or whatever....

The respondent who stated that a few people did all of the work in Town B1 commented that, if more of the residents had participated in CHIP, this would have been beneficial because "different people [have the potential to] lend great knowledge . . . you know, not necessarily book-smart, but street-smart." In addition, one of the individuals who provided contradictory statements concerning commitment to community noted that people's reluctance to commit much time had a negative effect on CHIP. She said that, initially, when people were offered an opportunity to participate in the process, there was a good response, but that "sometimes what happens is, 'okay, I've shared, so now I'm done'". So, over time, the membership "dwindled.".

Summary

A summary of the respondents' descriptions of the cultural characteristics is presented in Table 18. How each cultural factor was believed to have influenced participation in CHIP is summarized in Table 19.

Table 18
Description of Cultural Characteristics in Community B

Cultural Characteristic	Description
Priority given to health	Responses were divided. Half believed the community had a low interest in health; half believed that residents were very concerned about the availability and quality of health services. The perception of the local hospital was poor. Access to health care and services for the elderly or people with chronic disease were the primary health concerns mentioned.
Efficacy of collective action	Majority of respondents said that some, or most, of the residents believed in their collective ability to improve the community. In regard to health improvements, the residents recognized the challenge but were willing to try.
Insider *vs.* outsider differentiation	The coordinator was identified by most as the CHIP leader. She was well known in the outlying communities but was unfamiliar to residents of Town B1.
Sense of community/ Commitment to community	Sense of community was strong although divisions existed between outlying towns and Town B1. Commitment to community was quite strong also, however some respondents noted that a few people did everything, or that some residents were unwilling or unable to volunteer.

Table 19
Cultural Factors Influencing Participation in CHIP in Community B

Cultural Factor	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Priority given to health	Intangible benefit: CHIP raised awareness of health		Extent: High priority given to health and concerns about availability & quality of health services prompted people to participate Extent: Low priority given to health led to attrition of people from non-health sectors	
Collective efficacy	Benefits: Residents' optimism about making health improvements led them to address complex health problems		Extent: Collective efficacy contributed to willingness to participate and on-going investment in CHIP Effect: The community's self-reliance meant that residents viewed CHIP as exciting and important Extent: One said that lack of motivation to make change caused residents from non-health sectors to lose interest and drop out	

Insider *vs.* outsider differentiation		The coordinator's connections to residents of outlying communities enabled her to recruit many of these people to the CHIP team		Familiarity with the CHIP leaders meant that they were perceived as being credible Leader's unfamiliarity in Town B1 was good because there was no suggestion of bias Leader's unfamiliarity in Town B1 meant she lacked connections to key people; also it impeded communication and trust, and slowed the process
Sense of community; commitment to community	Decision-making: Weak commitment to community meant that diversity of input into decision-making was limited Benefits: Divisions between communities could result in benefits not being distributed throughout county	Strong sense of community contributed to diversity of representation; also that people who participated were not those who usually volunteer	Extent: Strong sense of community motivated people to participate and contributed to their commitment to find solutions to local health concerns Extent: Weak commitment to community meant that team members dropped out Effect: Strong sense of community meant CHIP was viewed as being important	

The Influence of Physical Factors and Social Structure on Participation

In this section, the respondents' descriptions of Community B relevant to four factors in physical setting and social structure are presented. In addition, their perceptions of how these factors influenced participation in CHIP are described.

Physical and Structural Barriers

The respondents in Community B identified four physical and structural barriers that were thought to have hindered participation in CHIP. Time constraints were frequently mentioned as being the reason that CHIP team members were unable to attend every meeting. In addition, one person observed that time constraints, specifically "the longevity of [the process] . . . the monthly meetings," made it difficult for young families to participate. The low-income population was hindered from participating because of lack of transportation and lack of access to a newspaper, according to one respondent. She stated, "how were [low-income people] supposed to get to the meetings? They don't take the newspaper; they don't see the advertising. . . . They wouldn't have known about it. And, if they did, how were they supposed to get there?" Another person commented that distance was a barrier that made participation burdensome for the residents of the outlying communities, yet she noted that this did not prevent them from participating. Other than a van serving disabled people in Town B1, there was no public transportation in the community. In addition, the towns within Community B were as much as 55 miles apart, with an estimated driving time of nearly two hours.

Besides these physical and structural barriers, two respondents also mentioned psychological or interpersonal factors that had served as barriers to participation for

youth and for the low-income population. These included not being personally invited and not feeling comfortable at CHIP meetings.

Although several people acknowledged that these barriers had hindered certain sectors from participating in CHIP, the majority of the respondents did not believe that this had a negative affect on the process. However, two people speculated that the outcomes of CHIP would have been different if these sectors had been involved. One stated, "if there had been more young parents involved, maybe we would have focused on getting a pediatrician. I do know as the process went on and where the focuses went . . . it definitely addressed the older community needs." Another person said that it would have been beneficial to have the input of youth when decisions were made regarding strategies for substance abuse prevention. However, this same individual denied that the involvement of the low-income population would have made a difference, noting that the CHIP team members recognized and addressed their concerns.

Civic Organization and Experience with Social Planning

The respondents reported that Community B has many voluntary organizations. A Chamber of Commerce document listed 23 fraternal or service organizations and 39 churches. The majority of the people described the voluntary associations as being robust and active. However, two respondents reported that the membership in these groups was small and a third person stated that many of the members were unwilling to participate in organizational activities. In addition to the voluntary organizations, the community had also formed other groups to address local needs. One group focused on human services and included representatives from the schools, the police force, the health department,

and the social service agencies. Another group was concerned with economic development.

When they were asked about the community's experience with social planning, some of the respondents reported that both the human services coalition and the economic development group had conducted strategic planning. However, very little health planning had occurred and several people were unaware of any community planning activities. Of those who were aware of previous planning efforts, only one person stated that positive outcomes had been achieved as a result of the planning. The others said that little had been achieved or that most residents would be unaware of the results.

The majority of respondents did not believe that the presence of voluntary organizations had influenced the community's participation in CHIP, even though several people noted that a number of the CHIP team members were active in other community groups. Only one person stated that the experience these team members had gained from their participation in other voluntary associations had been beneficial to the CHIP process. She said, "I think we had some people with a ton of experience that made the group stronger, made the process better."

Likewise, most of the respondents did not believe that the community's history of planning had influenced CHIP. Those who had described the outcomes of previous planning efforts as being insignificant said that this had did not have a negative effect on CHIP. They noted that "people came in with an open mind." However, one individual stated that a previous health planning activity, even though it only produced "a lot of

papers", had been beneficial to CHIP. She believed that the CHIP initiative evolved from this effort and noted that the findings from earlier assessments were provided to the CHIP team. Also, the person who reported that positive outcomes had been achieved through planning, said at this had contributed to a "'can-do' attitude" among the CHIP team members.

Leadership

Some of the respondents referred to a group of influential business people who were progressive, politically active, and powerful as the community's leadership. These leaders had been able to secure grants and make significant community improvements. Others noted that the administrators of the hospital, the social service agencies, and other key community organizations were proactive, collaborative, and skilled in management. However, the respondents also reported that the community had a group of leaders who were conservative and resistant to change. The recently elected officials were described as being ineffective and cautious, although, interestingly, several people noted that the previous officials had been "real savvy" and "much more creative". One person explained, "there's kind of a struggle between the people that want to see our community stay rural and small and close-knit, and the other ones that are a little bit more impatient that say, 'we need to grow.'" The respondents were divided in their assessment of whether the leaders were interested in and supportive of health issues. Some stated that the leaders recognized that high quality health services were critical for economic development, but others said that health is a low priority for the city and county officials.

The Community B CHIP team included very few leaders. None of the elected officials participated and neither was anyone from the economic development team involved. Some of the respondents noted that the leaders who did participate in CHIP (such as an administrator from the hospital and the director of a county human service department) made an intentional effort to remain in the background and not influence the process. When they were asked if the limited involvement of leaders had hindered CHIP, some people said that it had not. However, three people expressed dissatisfaction with the process due to lack of effective leadership on the team. One observed that meetings were poorly run because the people leading them lacked experience. She commented:

> Just organizing a meeting, starting a meeting, sticking to an agenda, not letting . . . you know. I'm so used to meetings being organized and having ground rules, and there's no war stories, and you speak for yourself, and all these kind of things. And, in general, community groups that haven't participated don't have that familiarity . . . the group process stuff.

The others stated that decision-making was impeded and attrition had occurred because of lack of leadership. For example, one person said that there were not enough leaders to guide the process, particularly when the team broke into sub-committees. As a result, the people who participated in the committees lost their focus, targeting problems of importance to them rather than the problems that were identified by the community, and many team members became discouraged and dropped out.

Only a few of the respondents commented on how the community's leadership, in general, had influenced CHIP. Two people noted that some of the leaders (possibly

physicians) were opposed to the plan to develop a rural health clinic and had, for awhile, obstructed the activities of the CHIP team:

> And see, there was a lot of leadership in Community B that didn't think that we needed a rural health clinic at all. . . . The people that put it forward persevered, and some of the old guard were saying . . . "there's this many providers and you're drawing a line down this side of the street and this side is not medically under-served and this side is?" and "you're dividing pieces of the pie." And I think they were too caught up in the semantics as opposed to how much good it would do . . . and maybe impact their private practices. [But the CHIP team] kept going . . . and now the guys that were majorly not in favor are just going along for the ride.

Another respondent expressed concern that implementation of the community wellness project would be hindered because of lack of support from the county commissioners.

On the other hand, one individual spoke of the successes the CHIP team had had in implementing its projects, particularly in getting federal approval for a rural health clinic. He noted that these successes were achieved with little funding and without the support of state organizations, and that strong local leadership, especially at the hospital, had made this possible:

> For a whole year we held ourselves together. We didn't have any staff money, so it was whatever we could do with what else we got. . . . We were implementing these various projects and such all of a volunteer kind

> of basis. . . . The HIPSA was, by far, the hugest deal. And I've got to tell you, we didn't get a whole lot of help from the state. . . . [But] it helps when you've got other people that have kind of been around the block a little bit too, you know. There are a number of people at the hospital level . . . that have played in health care big leagues. So, it's not just only people that have only worked in a little tiny hospital and just did this kind of thing like that. I mean, between [hospital administrator and vice president of patient care], they could work any place they wanted to in any size place in the country.

Resources

A review of the phone book and Chamber of Commerce documents revealed that Community B had a number of professional resources, including 16 accountants and 16 attorneys. The health care resources included a hospital with 36 acute care beds and a 12-bed intermediate and skilled care center. In addition, there were 15 primary care physicians, two general surgeons, two assisted living facilities, and a public health department with two full-time and two part-time nurses.

Nearly all of the respondents in this community agreed that the resources available to them were sufficient to support the CHIP planning phase. Several people mentioned that, in addition to the professional support that was provided by the ORH, this community had grant writers, lawyers, accounts, and others who either offered to help or would be willing to help in implementing the CHIP projects. The hospital employees were also identified as a valuable source of professional support. Only one

person said that professional support had been limited because of the lack of leaders on the CHIP team. All other resources were perceived to have been adequate. There was no shortage of funding, physical space, technical resources, or staff support.

This study was conducted more than a year after the planning phase had ended. Two of the respondents, who had dropped out of the CHIP team at the conclusion of the planning phase, expressed concern as to whether the community would be able to secure the funds needed to implement the projects that had been planned. However, the respondents who were still involved in CHIP were aware that grants had been received and that other sources of funding had not yet been tapped. Their statements suggested that they were confident that sufficient financial support was available.

Summary

A summary of the factors pertaining to the physical setting and social structure is presented in Table 20. How each factor influenced participation in CHIP is summarized in Table 21.

Table 20
Description of Factors Pertaining to Physical Setting and Social Structure in Community B

Physical and Structural Factors	Description
Physical or structural barriers	Time constraints, lack of transportation, lack of access to a newspaper, and distance were identified as barriers. Also, two psychological or interpersonal barriers were noted: not being invited and not feeling comfortable at CHIP meetings.
Civic organization and experience with social planning	Most respondents said that there are many active voluntary associations. In addition, other groups have been organized to address community needs. The community has engaged in some planning related to human services and economic development but has done little health planning. Most people were not aware of any outcomes achieved through planning.
Leadership	There were business leaders and administrators of organizations who were progressive, effective, and visionary. However, there was also a group of leaders who were cautious and conservative. The current elected officials were described as being ineffective and resistant to change.
Resources	Resources in all categories were sufficient to support the planning phase and the respondents who were still involved in CHIP were confident that resources were sufficient for implementation as well. The community had received grants to support the projects.

Table 21

Physical and Structural Factors Influencing Participation in CHIP in Community B

Physical and Structural Factors	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Physical or structural barriers	Benefits: A few respondents believed that the outcomes of CHIP may have been different if barriers had not kept certain sectors from participating	Barriers hindered the participation of several sectors including young families, youth, and the low-income population		
Civic organization and experience with social planning	Implementation: The reports from a previous health planning effort were available to the CHIP team		Form: One respondent said the members' awareness of previous planning successes led to a "can do" attitude	One person said that team members involvement in other voluntary groups strengthened CHIP
Leadership	Decision-making: The absence of strong leaders on the CHIP team led to weak decision-making Benefits: Leaders who resist change attempted to block one of the CHIP projects; weak leadership may impede implementation of CHIP projects Benefits: Implementation was successful because of the involvement of strong local leaders		Extent: The absence of strong leaders on the CHIP team led to member attrition	The CHIP group process was not satisfactory because the meetings were not run by people with leadership experience
Resources	Implementation: The resources contributed by the community, in combination with those contributed by ORH, were sufficient to support the planning phase Benefits: Implementation of projects had not been hindered by lack of resources			

Additional Findings

In this community, few respondents identified additional community characteristics beyond those that were included in the study's conceptual framework, and even fewer were able to explain how these characteristics had influenced participation in CHIP.

Poor Perception of Hospital

The residents of Community B had a poor perception of their hospital. One of the respondents speculated as to why this was true. He noted that, in Community B, the hospital was not a primary employer and proposed that this might be one reason that it lacked community support. (However, a Chamber of Commerce document listed the hospital as the second largest employer.) He also observed that several of the decisions that had been made by the corporate health system had not been popular:

> The thing about the hospital that's been difficult is that . . . some of the decisions that have been made by the parent organization in terms of the buildings and the financial decisions have been met with such disagreement that it's not looked on as an organization of esteem. And the other thing is that, with the economic stuff and with the rural health care problems, the layoffs . . . you know, we went through a huge number of layoff just within the last six months . . .and so the perception of . . . the hospital, the hospital organization, in the community is pretty poor.

He also observed that, in two other rural communities with which he was familiar, the hospitals were owned by local health districts, unlike the Community B hospital, which

was owned by a large multi-state health system, and noted that "there's a different sense of ownership there."

Ironically, the community's poor perception of its hospital had a positive effect on CHIP in stimulating participation. Respondents believed that "a desire to see the [local health] system improve" had motivated many people to participate in the CHIP activities. It was also noted that the community's poor perception of its hospital led to the decision to have another community organization sponsor CHIP, but whether this decision had a further effect on participation was not discussed.

Limited Communication

One respondent reported that Community B had few modes of communication and that those that existed did not reach many people. She believed that participation in CHIP was hindered by the fact that few people knew about the meetings.

Isolation

A respondent observed that her community, one of the outlying towns, was very isolated and, as a result, the residents had been excluded from previous planning events. Although, at the time of this study, the impact of the CHIP outcomes on this community was minimal, the process had provided the residents with an opportunity to express their needs. This respondent viewed this as a significant intangible benefit.

Summary

The additional community characteristics that were mentioned by respondents as having had an influence on participation in CHIP are summarized in Table 22.

Table 22

Factors Outside of the Conceptual Model That Influenced Participation in Community B

Community Characteristic	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Poor perception of hospital			Extent: The community's poor perception of its hospital motivated many people to participate	The community's poor perception of its hospital led to decision to have another organization sponsor CHIP
Limited communication		Limited modes of communication reduced the numbers of people who participated in CHIP		
Isolation	Intangible benefit: CHIP provided residents of an isolated community with an opportunity to express their concerns relevant to health care			

CHAPTER VII

CASE DESCRIPTION OF COMMUNITY C

This chapter describes Community C and its participation in CHIP. It is organized in the same manner as the previous two chapters, beginning with an overview of the community and its involvement in CHIP, followed by a discussion of the pattern of participation and the respondents' views concerning selected cultural, physical, and structural characteristics and their influence on CHIP, and concluding with a description of other community characteristics that facilitated or hindered participation in CHIP.

Community C Description

Community C encompassed a long and narrow county in western Oregon. In 2000, the population of this county was 44,479, up from 38,889 in 1990 (Office of Rural Health, 2003). The county included two larger towns and three small communities. The population of Town C1 was 5903 in 2000; the population of Town C2 was 9532. The majority of Community C residents, a total of 19,064, lived in unincorporated areas.

Town C1 was located 57 miles from a city of 141,150 people and 90 miles from a city with over 500,000 residents (Office of Rural Health, 2003). Town C2 was located 55 miles from a city of 52,450 people. The communities in this county were linked to each other and to larger cities by single-lane highways. Travel could be challenging due to weather (i.e., frequent, heavy rain and fog), winding roads that traversed low mountains

or followed the coastline, and heavy tourist traffic (particularly during the summer months).

The residents of Community C were older, poorer, and less educated than residents of the state as a whole (see Table 23). However, the demographic characteristics of this community were closer to the state averages than were those of either Community A or Community B. Tourism was the primary industry, with nearly 21% of the population employed in arts, entertainment, recreation, accommodation, or food service (U.S. Census, 2000). Education, health, and social services were the second highest source of employment at 16%. The CHIP coordinator noted that employment patterns were very different in the towns that were located inland, away from the coast. In these areas forestry was a major employer.

Table 23
Selected Demographic Characteristics of Community C as Compared to Oregon[1]

Demographic Characteristic	Community C	Oregon
Median Age	44.1 years	40.0 years
Percent Below Poverty	13.9%	11.6%
Median Household Income	$32,769	$37,938
% Population Age 25+ Without High School Diploma	15.1%	14.9%
Average Unemployment Rate	6.9%	6.3%

Note. [1]ORH, 2003.

Community C had two hospitals, both of which were managed by a health system that was based outside of the county. This health system served as the sponsoring agency for CHIP. The CHIP team met from September 2002 to July 2003. There were 41 members, but only 19 attended meetings regularly. At the time that this study was

conducted, in the fall of 2003, the full team had not met since the July meeting and many of the respondents were unaware of any plans to reconvene. Two of the sub-committees, however, remained active and the coordinator, who was still employed on a part-time basis, was working on some of the projects. Three of the goals had been achieved.

How Participation Was Enacted

Cohen and Uphoff's (1980) framework for participation was used as a guide for developing this case study description of community participation in CHIP. Table 24 presents a summary of Community C's pattern of participation.

Table 24
Dimensions of Community Participation in CHIP in Community C

Dimension of Participation	Description
What Kind of Participation Occurred	
Participation in Decision-Making	Team members, who mainly represented health and social service agencies, had control over decision-making but other sectors had little involvement. Team members came with "agendas" that influenced their decisions. Some said decision-making was controlled by agency personnel who wanted funding for their programs. Nearly all team members were comfortable with making decisions.
Participation in Implementation	Community C provided an office, equipment/supplies, meeting rooms, and labor. Funding for coordinator's salary came from corporate health system rather than local health districts. But funding for implementation had come from the community.
Participation in Benefits	Some public health programs that were slated for elimination were sustained and several new projects were planned. Grants had been received. Intangible benefits included: stronger social networks, expanded leadership, enhanced collaboration between hospital and public health, improved morale among public health employees, and helped health system learn about the community.
Who Participated	The core group of active members was predominately female, middle-aged or senior, and Caucasian; 58% represented the health care sector. Groups that were under-represented or missing included Hispanic and Native American populations, low-income population, business sector, communities from east side of county, youth, and men.

How did Participation Occur	
The Basis of Participation	The health system that managed the hospitals in Community C requested to participate in CHIP in order to fulfill a contractual obligation with the local health districts.
The Form of Participation	The aim was to recruit people who were active in diverse sectors of the community. Populations at risk were represented by advocates or agency personnel.
The Extent of Participation	The time commitment that CHIP required was viewed as significant, even overwhelming. Less than half of the team members attended regularly; attrition was high. Time constraints and personal agendas contributed to the attrition. The community remained invested in CHIP after the planning phase, though on a limited basis. The full team had not met since completing the plan.
The Effect of Participation	The community-at-large was not aware of or did not understand CHIP. Some team members did not perceive CHIP as a priority or were dissatisfied with the outcomes. Of those who remained committed to the process, many viewed CHIP as worthwhile but some were disappointed.

What Kind of Participation?

This section describes participation in decision-making, participation in implementation, and participation in benefits.

Participation in decision-making. As in the other CHIP communities, the Community C CHIP team analyzed data provided by the ORH on health status and health service utilization and compared this to the feedback they received from residents concerning local needs and adequacy of local health services. To gather input from residents, the team members conducted key informant interviews and organized two community meetings, one on each end of the county. A total of 115 people were interviewed and approximately 50 residents attended each of the community meetings. After identifying 24 areas where the community's concern about an issue was supported by the statistical data, the team members used a forced choice process to select six priority health concerns. Sub-committees planned strategies for addressing each of these.

Upon completion of the planning phase, the team received a grant from the ORH and decided how to distribute the funds among the strategies, or projects, that had been chosen.

The majority of respondents said that the CHIP team members (who, for the most part, were associated with health or social service agencies) had control over the decisions that were made, but the community in general had little involvement. For example, one person said:

> Well, [CHIP] certainly [had representation] from the provider and public service perspective. . . . As in many of these endeavors, you get obviously a good deal of interest from people who are directly involved and that was clearly the case. It's always a struggle, and it indeed was in this case, to involve the general community.

However, a few respondents noted that an effort had been made to involve people from diverse sectors in the planning. One said, "I think they did a very good job of trying to achieve broad-based representation. And by that I mean different disciplines as well as different areas of the county." And another stated:

> I think the process was very fair. The needs were identified through surveys that each of the committee members sent to circles of their contacts. And we each tried to target different groups. Someone targeted seniors; someone targeted young people; someone targeted gays; I chose dual-employed people.

One theme that emerged often in interviews with the Community C respondents was that many of the people who participated in CHIP meetings came with an "agenda," a goal of finding support for their organization or their cause.

> It was clear that not everybody . . . had the same agenda at the beginning. And I think some people might have been there . . . to find out how to get some money to bail out their agency or their cause. Or they saw a very specific need and they were there to get that need addressed.

Some of the people who mentioned this stated that having an agenda was "natural" or to be expected, and they did not believe that this had negatively affected the process. One respondent explained that the structure of the CHIP process ensured that the decision-making was fair and said that the issues that had emerged from the community meetings paralleled the team members' assessment of community needs. However, others thought that the process had been biased and that agency personnel, particularly public health employees, had controlled the outcomes.

> I figured it out. Because all the public health people sit over here; all the hospital people sit at one table; all the school people sit at one table. And then, in the back, here was my group. . . . And the people that sit at the tables all together, well they go and do the whole thing. So I think that was kind of a biased way that was all set up. . . . At times I felt like there was a different agenda and that people—a set of people—knew what was going to happen regardless of how many meetings we attended.

The ORH staff member who attended the CHIP meetings did not influence the team's decisions, according to most respondents. One individual, however, observed that the ORH staff member had a strong personality and said, "I felt that he, maybe unnecessarily at times, shaped the decision-making process almost as though some of them might have been preconceived. That might not be true."

All but one of the respondents said that the CHIP team members had been comfortable with the decision-making responsibility. One person stated that she had been rather overwhelmed.

Participation in implementation. Community C, like all communities that participate in CHIP, was required to provide half of the salary for the coordinator, as well as office and meeting space, and supplies. However, in this community, the funding for the coordinator's salary did not actually come from the local health districts but was provided by the health system that managed the hospitals. The coordinator used an office that was located in her home. This office was equipped with a computer, telephone, fax machine, and filing cabinet. Meeting spaces and meals for the CHIP team and sub-committees were furnished by the hospital in Town C2. The hospital in Town C1 provided postage, copy services, and handled the mailings. A church and a recreation center offered their large meeting rooms for the community meetings. Several local agencies, including the hospitals and the county public health and human services department, paid their employees to attend CHIP meetings. Other community members, mainly retirees, volunteered their time.

The physical facilities available to CHIP were sufficient. The coordinator's office was convenient and well equipped. The hospital in Town C2 had three rooms that were used by the CHIP team: a large room for full team meetings and two smaller rooms for the sub-committee meetings. All had modern audiovisual equipment, including teleconferencing equipment, which team members used to consult with professionals outside of the community. The only challenge that was observed pertinent to the facilities was that the Town C2 hospital, although centrally located in the county, was a considerable distance from Town C1 and several of the other communities, and thus was inconvenient for several members.

Participation in benefits. As a result of their participation in CHIP, Community C chose to address six areas of concern. Their goals included (a) to sustain funding for a prenatal case management program and a program that provides free immunizations to low-income children; (b) to sustain funding for four school-based health centers; (c) to enhance diabetes education and secure a federal grant for diabetes management; (d) to promote health throughout the county with worksite wellness programs, a parish nurse program, and programs encouraging exercise and good nutrition; (e) to produce a health referral guide; and (f) to investigate options for expanding health insurance coverage, beginning with an employer health benefits survey. At the time of this study, the community had received $176,000 in grant funding, most of which was provided to the public health department to replace state funds that had been lost for the free immunization program, the prenatal case management program, and the school-based

health centers. All of the other strategies were being pursued but had not yet been implemented.

As in the other two communities that were studied, the respondents in Community C reported that several social benefits were gained as a result of their engagement in CHIP. Some respondents said that CHIP brought the communities together and built networks between people who were advocates for community health. Others noted that CHIP expanded local leadership; boosted morale, particularly among county employees; enhanced collaboration between the hospital and the public health department; and helped the new corporate health system learn about the county.

Who Participated?

The CHIP team had 41 members but the coordinator reported that only 19 of these were active participants. Most of the 41 members were female (78%) and Caucasian (98%). One person was Asian. Twenty six (63%) were between 40–59 years of age; ten (24%) were in their 60's; three (7%) were in their 30's; one person (2%) was 22 years of age; another (2%) was 85. Among the core group of members who participated regularly, 15 (79%) were female and all were Caucasian. Nine people (47%) were between 40–59 years of age, one (5%) was in her 20's, eight (42%) were in their 60's, and one person (5%) was 85.

The constituencies or organizations represented by the full team, as well as by the core group, are shown in Table 25.

Table 25
Constituencies Represented by CHIP Team Members in Community C

Constituency or organization represented	Number invited	Number active (core group)
Health care	19	11 (6 from public health)
Business	7	0
Arts community	1	1
Seniors	3	2
Local government	1	0
Faith	2	0
Education	1	0
Low-income families	4	2
Families & children	3	3

Other people who participated in CHIP were the coordinator and a staff member from the ORH. The coordinator was a young White woman. Although she viewed herself as representing the entire community, the respondents saw her as representing the health sector because this is where she was employed. The ORH staff member represented his organization, which was located in a major city outside of this county.

Neither the full CHIP team nor the core group of active members reflected the diversity of the community. In Community C, 19.5% of the residents were 65 years of age or older and 23.7% were age 19 or younger (Office of Rural Health, 2003). Also, 5.3% of the population was Native American, 4.8% was Hispanic, and 4.7% included other ethnic minority groups (U.S. Census Bureau, 2000). Thus, persons 60 years of age or older were over-represented on the team, particularly among the core group of members, and men, youth, and people from ethnic minority populations were either under-represented or missing.

The respondents recognized that the CHIP team was limited in its diversity. Several people noted that health care providers, particularly those in public health, were

over-represented. Others mentioned that seniors were over-represented as well, although one person observed that there was no one on the team who was familiar with the health care needs of seniors, such as nursing home administrators or medical internists. Sectors that were observed to be under-represented or missing included the Hispanic and Native American populations, the low-income population, the business sector, communities from the eastside of the county, and youth.

How Did Participation Occur?

This section describes the basis of participation, the form of participation, the extent of participation, and the effect of participation.

The basis of participation. Community C had two health districts, both of which had recently entered into affiliation agreements with a corporate health system. Both of the agreements specified that the health system would conduct a community health assessment. CHIP was viewed by the health system administrators as a way to fulfill this contractual obligation, and so they contacted the ORH (personal communication, P. McGinnis, March 5, 2004).

Although most of the respondents were not aware of the details concerning the affiliation agreements, they had a general understanding that the health system wanted to gather input from the community concerning their health needs and their perceptions of local health services. For example, one person said:

> It was at the time when [health system] was taking over. And I believe that they wanted to see what they could do to be more proactive in the community. . . . It was a good way for them to find out what do people in

the community think about this health system and what's happening in the health community.

The form of participation. The Community C CHIP coordinator used two criteria in determining who to invite to participate in the CHIP team. First, she focused on recruiting people from diverse sectors of the community, as the CHIP manual recommended. Second, she sought to involve people who were active within their sector, although they were not widely recognized as being community leaders. She explained:

> Well, the CHIP manual lists different segments that you need to get. So I pretty much tried to follow that and then, you know, if it said 'two people from social services", then, because I know the community and know who the movers and shakers are, I tried to [recruit them]. ... I look at my CHIP leaders as . . . probably leaders in whatever little group they were representing. Whether it was in their church or something they volunteered for. But I think CHIP has allowed them to expand and to be seen by the whole community as a leader.

In this community, populations at risk, such as the poor, were represented by advocates or agency personnel.

The extent of participation. The CHIP team met ten times over a period of eleven months. Attendance was not recorded. For the first five months, meetings were held every two weeks. Later, after the sub-committees formed, full team meetings were held less often but the sub-committee meetings occurred monthly. Some team members participated in more than one sub-committee and so had more meetings to attend. In

addition to participating in these meetings, team members were asked to interview several key informants and take part in one of the community meetings.

All of the people who were interviewed said that CHIP demanded a significant commitment of time from participants. One person said, "It was overwhelming. I thought it was. Partly because most of the folks in the group were not retired; they were working people. And so they had to take time off from work to be there."

The respondents noted that a small group of people were very committed and attended the meetings regularly, but a substantial number of others either dropped out or attended sporadically. Several people blamed the attrition on the amount of time that was required. For example, the coordinator stated, "I lost the business sector by about the third meeting. . . . They all felt like they just didn't have the time." Another person said:

> There were a lot of drop-outs rather early on, and so there was never the full 30 or 35 that they thought there was going to be. It was really closer to half that. . . . I think they didn't realize really what was expected of them. There was a lot expected. The time commitment in the process was definitely high. So, they might have felt burdened with that.

However, other reasons for the attrition were also given. These included members having other priorities or feeling confused about the process. One respondent said that some people dropped out when they were not able to get funding for a project or cause: "I think that some of the people that left had initially joined because they'd heard there was money was available, and when it wasn't fairly quick in showing up, they needed to move on." Similarly, another commented, "If they came with that personal agenda and

they saw it wasn't going to be addressed, then 'well, I'm out of here.'" Two of the respondents reported that people dropped out because they believed that a small group of health department employees were controlling the process and outcomes.

Despite a less than strong commitment during the planning phase, this community's investment in CHIP had continued, albeit on a limited basis. CHIP funds were used to pay a portion of the coordinator's salary so that she could continue to work on some of the CHIP projects. Two of the sub-committees had continued to meet monthly to pursue their goals. Some of the other sub-committees had submitted grants or had taken other actions that were pending at the time of this study.

The effect of participation. Some of the respondents said that the community-at-large was unlikely to be aware of CHIP or its outcomes, or would have difficulty understanding the process. In addition, one respondent observed that some of the team members did not view CHIP as being a high priority and so had dropped out. Another stated that "those that saw something come out of it that was compatible with what they were seeking in the first place … would see it very favorably", but he noted that some people left the team because CHIP did not address their concerns. A small number of respondents expressed disappointment with the outcomes of CHIP, stating that they did not feel the community benefited from the process. However, others noted that the team members who had remained committed to the CHIP process were "very positive" and "very excited" about the outcomes.

Cultural Characteristics and Their Influence on Participation

This section presents the respondents' descriptions of their community relevant to the four cultural factors that are part of the conceptual framework for this study. In addition, the respondents' perceptions of how these characteristics influenced their community's participation in CHIP are described.

Priority Given to Health

Some of the respondents in Community C said that health was a high priority for the community. For the most part, this was attributed to the large number of retirees who had settled there, although a few people noted that health was a priority because of the high proportion of residents who were poor or uninsured. One person explained:

> [Health is ranked] very high. Again, because we are . . . people who visit the doctors frequently. About 70 to 75 percent of our gross revenues, when I was on the [health district] board came from the treatment of Medicare and Medicaid patients. . . . It shows you what the demographics are here. . . . When I retired, I didn't have anything to do so I sold real estate for awhile. . . . I don't remember anyone asking me about the education system because . . . their children were already educated. But invariably they would ask about the health care system.

Other respondents said that health, although important to the community, ranked behind other issues such as economic development, infrastructure improvement, and schools. One person stated that the priority given to health had declined in recent months

because the community was more satisfied with local health services now that these were being managed by a corporate health system.

Access to care (including insufficient numbers of physicians, few medical specialists, and insufficient health insurance coverage), chronic disease, and health care for the elderly were the community's primary health concerns. One person added that the primary health concerns of young families would be drug abuse and teen pregnancy.

Only a few of the people commented on how the priority given to health had influenced participation in CHIP. One person, who believed that health was not a high priority for many residents, said that this was reflected in the membership of the CHIP team. He noted that CHIP team consisted mainly of people who were involved in some aspect of health care because, for them, unlike the community-at-large, health was important. Similarly, two of the respondents said that the team members perceived CHIP as being important and were committed to the process because, for them, health was a priority. However, a fourth person, who believed that health was fairly important to all of the residents, said that this was evident in the interest that was shown in CHIP among the members of her hometown.

Perceived Efficacy of Collective Action

The respondents' comments regarding collective efficacy varied. A few people said that the residents believed that, by working together, they could bring about positive change. For example, one person stated:

> I've seen a number of examples of that. Not particularly in medicine, but in providing facilities for children. We got a new skate park here all

> because of local folks. We worked together, raised the money, and worked with the city fathers and got it done. And there's a number of examples of that kind of thing. They can be effective if they believe that something is worthwhile.

Another respondent observed that, because of the community's isolation, residents recognized the need to "pull together" to solve problems. Yet, a little later in the interview, this same individual stated that the community's isolation led to skepticism about whether improvements were possible. A third person explained that, due to the high level of poverty in this area, residents "hunker down and try to take care of their own" and had little interest in improving the community. One man spoke of the "overt negativism" that was prevalent, as opposed to a spirit of cooperation. A few of the respondents stated that the community was divided between those who believe in their collective ability to bring about change and those who do not.

One person said that the community's recent success in obtaining affiliation agreements for their hospitals had led to a belief that health improvements could be achieved through collective action. However, the majority of the respondents were more tentative. Some noted that residents were overwhelmed by the complexity of the health care system. For example, one person said that health care is "so complex anymore, with all of the monies going hither and yon and not having any say-so about it, that people get discouraged. … And so … a lot of people feel, 'well, what can I do?'" Others spoke of the magnitude of the community's social problems, which led to discouragement as well.

> We have the highest per capita alcohol consumption of any county in the state. We have the highest population of teen unwed mothers of any county in the state. . . . A lot of people come to the end of the earth because that's the last place to go because they don't care anymore. So in a way . . . no matter how many people care, there's always going to be this contingent that's going to balance them out.

Yet, these respondents and others said that a degree of optimism existed. One person provided an example of a community member, a nurse, who spearheaded an effort to develop a rural health clinic despite being told that this could not be done. Others noted that, while the residents in general did not believe in their collective ability to improve health, the health or human service providers tended to be optimistic.

The community's ambivalence about whether health improvements could be achieved had an influence on CHIP membership and attrition according to some of the respondents. It was noted that the people who remained committed to CHIP (who primarily represented the health sector) were the optimists: "They were the champions. They were the cheerleaders. They were the believers." However, many people dropped out because they were overwhelmed by the goals or thought the process would fail. One respondent noted, "There were … a couple who voiced their [concerns] . . . you could tell on the second get-together that they weren't going to stay. They felt that the goals were too overwhelming that . . . nothing could ever really be done." Another said, "when the CHIP . . . process started, one of our county commissioners walked out of the meeting because she said it will not work. So that's how the tone was set in the very beginning."

The ambivalence about whether health improvements were possible may have also affected the meaning given to CHIP, at least initially. One respondent reported that even the loyal team members were skeptical at the beginning. She stated, "They were certainly verbal about that: 'Are we going to put in all this time and nothing will come of it?' But . . . over time they bought into the project . . . particularly when the funding starting coming our way."

Insider vs. Outsider Differentiation

In this community, both the coordinator and the ORH staff member were identified as the leaders of CHIP. Some of the respondents said that the coordinator was the person who was most likely to be perceived as the CHIP leader because "she is someone from the community". Others, however, viewed the coordinator as an administrative assistant and said that the ORH staff member would have been identified as the leader because of his strong leadership style and his knowledge.

The coordinator was known to all but one of the respondents prior to CHIP and was considered to be a community insider. She had previously been employed with the hospital in Town C1 but was working for a regional organization at the time that CHIP began. Both the coordinator and another respondent commented that it was to her advantage that she was no longer employed in Town C1 because residents who lived elsewhere in the county might have perceived her as having a bias in favor of that community. The ORH staff member resided in a metropolitan area outside of this county but was known to at least two of the respondents prior to CHIP.

The coordinator's status as an insider was considered, by most of the respondents, to be helpful but not essential in facilitating CHIP. One stated that, because the coordinator was a local person, CHIP was perceived as being a community project. Others noted that, because she had connections to people, she knew whom to recruit. Her familiarity with the community also meant that she understood local issues and was able to make helpful suggestions during the CHIP deliberations. Yet, despite these advantages, many of the respondents said that an outsider who had strong leadership skills could have been equally successful. In addition, a few people stated that there were both advantages and disadvantages of being an insider and that this community had some history of preferring to work with people who were not as close to the issues:

> Oooo, that's a tough one because if they were known, they may be able to influence those that are influential. But if you don't have somebody with skill . . . the process won't continue. Or you don't like them . . . then you could torpedo. . . . See, we've had some past history too. . . . A . . . local man was brought in to mediate. And then everybody said, "oh, no, he's too close to that" and took him away from the position. So I think there's some history that people just want to have somebody new from [outside] the area.

The ORH staff member's status as an outsider was not perceived as being a hindrance to CHIP by most of the respondents. A few people explained that whether a person is an insider or an outsider was not a concern for this community. One said:

> We're so used to different people. And they come from everywhere. They come from the valley, they come from California, they come from Washington. It is not something that divides the county at all, to my knowledge. I have not sensed it.

Several others noted that the ORH staff member was liked and welcomed by team members. One described him as being "refreshing; a breath of fresh air."

However, the participants in one focus group were negative in their remarks about the ORH staff member. They noted that he was "too far distant … not in our realm" and said, "he was always saying … he just got back from someplace way far distant, and he was going someplace else way far distant. And, is he really with this group or not? Did he really care [about] what we were doing…?" They believed that he perceived himself as being the CHIP leader because he had access to data, but they resented the data and felt that it didn't provide a complete picture of their community. One person, in particular, expressed anger or irritation in having an "outsider" tell them what their problems were and what should be done to address these:

> The community is … it's a group of peoples' home. And you've got an outsider coming and telling them how to take care of their home and it's because of such and such of logic or formula that was done . . . .statistical analysis. You don't do that! I wouldn't walk into your home and, you know . . . seriously! . . . and tell you, you've got to do this type or do this this way because this is what the stats say that it should be done.

For this group of respondents, the ORH staff member's status as an outsider led to strong feelings of dissatisfaction with the CHIP process. They believed that much of the attrition occurred because others were equally dissatisfied with the ORH staff member. In addition, they stated that their approach for coping with ORH staff member was to ignore the data he brought and make decisions based on their own assessment of the community.

Sense of Community and Commitment to Community

According to the respondents who resided in Town C2 or in the outlying communities in the county, the sense of community within these towns was strong. They described the residents as being "close knit" and willing to help each other. However, the respondents who lived in Town C1 said that the sense of community in this town was not strong. They explained that this community once consisted of six small towns that were merged to form a larger community, and that the long-term residents still viewed these areas as being separate. This community also attracted many retirees and one respondent said that the retirees' ties were with the community they came from, rather than with Town C1. Others noted that, because Town C1 was heavily based on tourism, there were a large number of temporary residents, including seasonal workers as well as people who owned or leased second homes in the community. These people were not connected to the community and, in addition, the presence of so many temporary residents disrupted the sense of community for those who lived there permanently.

The respondents uniformly noted that divisions existed between the towns within Community C. Although a few people said that some towns collaborated with their

nearest neighbors, all observed that geographic barriers had created distinct regions and even different cultures within the county. These regions were not integrated and, in fact, competed against each other. Several people described long-standing resentments that existed between the regions and some cited the presence of two hospitals in the county as proof of the lack of integration. A small number of respondents also stated that divisions existed between groups of people based on socioeconomic status.

The commitment to community was described by most of the respondents as being strong, even in Town C1 where all who were interviewed said that there was a high degree of volunteerism, particularly among the retirees. One person, however, said that volunteerism was average in his community and another noted that few residents were willing to participate in planning activities.

Only a few of the respondents commented on how either the sense of community or the commitment to community had influenced CHIP. One person stated that the willingness of residents who were not affiliated with health agencies to participate in CHIP was a reflection of the strong sense of community. Despite the fact that over half of the team members represented the health sector, he was impressed with the involvement of the community-at-large and noted that, in an urban setting, health planning would be left up to "the paid staffers of all the different agencies and that's about it." Similarly, another respondent said that the strong sense of community in her hometown contributed to the fact that this very small community had two representatives on the CHIP team. Others said that the involvement of many active retirees in CHIP was a result of their strong commitment to community.

Only one person said that the divisions between communities had hindered CHIP. She commented that the residents of a Native American town had not participated even though they had been invited. On the other hand, the majority of the respondents said that CHIP was beneficial in that it brought the communities together and created networks and linkages that had not existed previously.

Summary

Table 26 summarizes the respondents' descriptions of the cultural characteristics of their community. Their assessment of how each cultural factor influenced participation in CHIP is summarized in Table 27.

Table 26
Description of Cultural Characteristics in Community C

Cultural Characteristic	Description
Priority given to health	Responses ranged from health was a high priority to health was less of a priority than other issues. For retirees, health services were very important. The health concerns most frequently mentioned were access to care, chronic disease, and services for the elderly.
Efficacy of collective action	Responses concerning collective efficacy in general varied. Some said residents were optimistic, others said they were not. Health problems seemed overwhelming to many, but some people believed that positive change could occur. Those who were involved in health and human services tended to be the optimists.
Insider vs. outsider differentiation	Both the coordinator and the ORH staff member were identified as the leaders of CHIP. The coordinator was known to nearly everyone and was considered to be an insider. The ORH staff member was from a large city outside of this county but was known to at least two of the respondents prior to CHIP.
Sense of community/ Commitment to community	The sense of community was strong in Town C2 and in the outlying towns, but was weak in Town C1. Divisions existed between regions in Community C. Commitment to community was described as being strong by most respondents. There was a high level of volunteerism, especially among retirees.

Table 27

Cultural Factors Influencing Participation in CHIP in Community C

Cultural Factor	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Priority given to health		The lower priority given to health meant that CHIP team members were people who were involved in health care; there was little involvement from the community-at-large	Effect: Those who perceived health as a high priority also viewed CHIP as being important Extent: That team members perceived health as a high priority contributed to their commitment to CHIP	
Collective efficacy		The people who participated in CHIP were the optimists; those who believed health improvements were possible	Extent: Those who did not believe that health improvements were possible dropped out of the CHIP team Effect: Ambivalence about ability to improve health meant that team members were initially skeptical	
Insider *vs.* outsider differentiation	Decision-making: ORH staff member's status as an outsider led some team members to ignore his data and to make decisions based on their own assessment of the community Decision-making: Coordinator's status as an insider meant that she understood local issues		Extent: Some respondents believed the ORH staff member's status as outsider contributed to attrition	CHIP was perceived as a community project because coordinator was an insider ORH staff member's status as an outsider was viewed as an asset by some; he was not too close to the issues Some team members were dissatisfied with the involvement of the ORH staff member because he was an outsider

Sense of community; commitment to community	Intangible benefit: CHIP reduced barriers between communities	Strong sense of community prompted residents who were not affiliated with health agencies to participate in CHIP The retirees' strong commitment to community led many to participate in CHIP One respondent said that divisions between communities meant that Native Americans were not represented on the CHIP team	Extent: Strong sense of community in one small town meant that they had two representatives on the CHIP team	

two daily stops in each town. In this community, no psychological barriers were mentioned.

Despite the fact that sectors were excluded because of barriers, most of the respondents did not think that the community's participation in CHIP had been hindered. Two people observed that the CHIP team included members of advocacy groups and human service agencies who represented the interests of the sectors that were missing. One of these individuals, a public health supervisor, explained, "I . . . wanted my maternal/child health nurse there . . . She reads every chart of that family. I mean, even if they're not there, there is a voice because we know what they're doing and we can articulate." However, another respondent observed:

> I think it would have been different. I don't know if I can answer how. I don't know if the issues that the social service agencies perceived are the issues that the clients might perceive. I don't know. I think we just won't know that.

Civic Organization and Experience with Social Planning

All of the respondents stated that Community C had many active voluntary associations. A Chamber of Commerce document listed 47 fraternal and service organizations and 66 churches. The majority of the respondents also agreed that there were a great number of volunteers, although one person said that the same people tended to participate in all of the voluntary groups.

In this community, a large number of the respondents were aware of previous planning activities, particularly in relation to health. Several people who resided in Town

C1 recalled a major strategic planning effort that had focused on the future of the hospital and had resulted in the decision to affiliate with a health system. One person spoke of the community's involvement in a rural health initiative that was sponsored by a large university. Another reported that an outlying community had organized a task force to develop a rural health clinic. Others mentioned countywide planning activities that had focused on public health, mental health, and support for families and youth. For the most part, the respondents believed that these planning efforts had been successful. A negative outcome was reported in only one of the interviews, where the participants in a focus group stated that a program that evolved from a plan for mental health services was too costly and was inaccessible.

Most of the respondents did not believe that participation in CHIP had been influenced by the fact that the community had a high level of civic organization. However, one person noted that the involvement of active volunteers in CHIP was beneficial because these were individuals who, because of their participation in numerous community organizations, had a thorough understanding of community needs and gaps in services. Another observed that the voluntary associations had been, and may continue to be, a source of financial support for the CHIP projects. A third person said that the fact that the community was organized contributed to the team members' ability to gather public input. He noted:

> I was sort of surprised at how well they were able to get the interviews done—I think there were more than a hundred interviews that were done, which to me is an indicator of community organization. I think the fact

> that they did have two fairly successful, well-attended meetings . . . also was indicative of the ability of the group to produce an outcome.

Among the respondents who were aware of the community's experience with health planning, most agreed that this had had a positive influence on CHIP. Several people said that, because the CHIP team members had participated in previous health planning efforts that had proven to be successful, they were willing to make a commitment to CHIP. In addition, one person commented, "I think that the people who participated in CHIP, a lot of them had familiarity with this kind of process and that helped the process." (It should be noted, however, that some of the CHIP team members, particularly the retirees, acquired experience in planning before they moved to Community C.)

Leadership

The respondents provided varied opinions concerning the strengths and weaknesses of the local leadership. Several people spoke about the elected officials and characterized them as being weak. They noted that the leaders were neither inclusive nor bold, had poor problem-solving skills, and lacked a vision for making the community a better place. One person said that there was significant turnover and little professionalism among the elected leaders. He attributed this to the fact that most were volunteers rather than paid employees. Others reported that the leaders had little interest in matters pertaining to health. One person said that this was because they had so many issues to be concerned with. He noted, "I think they're all well intentioned but we all

have so much of our time taken, focused on issues at hand." However, another person stated, "they're all insured; I don't think they care."

Some of the respondents were positive in their assessment of the leadership. One person, a public health supervisor, observed that the county commissioners had been generous in supporting public health programs. When asked if these leaders were bold, she stated, "I think it's not the climate in which to be bold" but then went on to explain, "I think that we have very intelligent leaders here. I think that ... incredible things happen here. . . . I wouldn't use the word bold, but I would use the word intelligent and thoughtful in terms of the leadership here." Another individual, however, did view the leaders as being bold in addition to being inclusive and skilled in management. She attributed their boldness to the fact that many were retirees:

> . . . a lot of [the officials] like city government are volunteers. And, again, who are those volunteers? A lot of them are retirees, people who come from a pretty interesting, useful background. And it may be, because they're retired, maybe they're more open to speaking their mind because if someone doesn't like it . . . they can just say, "okay, I won't volunteer for this anymore." I think that has an influence when you have a lot of retirees running city governments. And they're running the hospital boards. I mean, most of those are retired people, so. . . .

A third group of respondents provided a mixed response when describing the community's leadership. One person said that, in her hometown, the "non-elected leaders are more influential" than the elected officials. She observed that the non-elected

leaders were very bold and energetic. Another stated that his community currently had strong elected leaders but noted that there was a lot of turnover because residents tended to be transient. However, like the individual who stated that many of the leaders were retirees, this respondent also revealed that his community had, among its retirees, people who had a high level of leadership skill and "connections." He referred to one woman, a member of the local health district board, who was a regent with a major health science university, and also noted his own background as the recently-retired director of a health department in a large metropolitan county in another state.

Finally, two respondents who participated in a focus group reported that this community had a small group of leaders who had a great deal of power and control and that one of these leaders was the director of the county health department. They described this leader as being interested in expanding his department, often at the expense of other programs and people, and said that he exerted much control over meetings and processes pertaining to human services in the county.

> And in this community, there's some real key players. I mean, I can say, there's about three. . . . Our human services director . . .puts this little person in there to feed him all the info about what's going on at all the meetings. . . . And monies that come into the county have decisions made about by him. I mean there's no process. He just says, "okay, that's my money." . . . There's been three positions in the community that were pretty high-pay salaries that now the . . . human services has total control over. . . . He wanted the Commission on Children and Families because

> the money was coming in. And it happened. And—poof!—the old director lost her job. Well, she quit under stress, total stress. And he took it over.

Only one of the respondents believed that the weaknesses of the local leadership could have a negative effect on CHIP. She stated that the fact that the leaders were not bold might mean that they would be unwilling to support some of the more innovative strategies that had been explored by the CHIP team members. Others were more concerned about the absence of leaders from the CHIP team than the weaknesses of the leaders. There were no elected leaders and, according to some people, few unofficial leaders on the Community C CHIP team. A few of the respondents stated that the team members were limited in what they were able to accomplish because leaders were not involved. One explained, "because we don't have any money, because we don't have any power, we can only change incrementally. We can't change policy." Another person believed that CHIP would fail because the leaders who could leverage resources were not involved. He said:

> In a community like this . . . we cannot do some of the things that we will need to do to bring better, more comprehensive, medical care to the folks without approval of bond issues. Those public policy makers, those opinion makers who are influential in determining whether bond issues get passed or not, none of them were on the CHIP committee.

Other respondents did not believe that the absence of leaders would be a hindrance in achieving the CHIP goals. One person explained that, "to the extent that the

leaders recognize the CHIP process as being a good process, being a contributory, participatory process", they would be supportive. The coordinator concurred, saying:

> I think that, in the beginning, they were skeptical also. But I've been in contact with two of our county commissioners who are going to be working on our school-based health center project. [And] I think they're believers now and I think they will be supportive.

Two of the respondents, who had described the strengths of the retirees who were serving in leadership positions, said that the skills and knowledge that the retirees brought to the CHIP team had facilitated the planning process. One person observed that it was helpful to have people on the CHIP team who were familiar with planning processes. The other respondent said:

> [The] retirees are, you know. . .the people we had have really interesting work backgrounds and a vast amount of knowledge. I think they were really . . . kind of key to holding things together because they've got the time and the knowledge to keep us on track, the rest of us who are working.

Lastly, the respondents who said that decisions pertaining to human services were controlled by a small group of leaders reported that this dynamic was evident in CHIP. They believed that the director of the health department and his staff influenced the voting during one of the CHIP community meetings. As a result, most of the CHIP funds were provided to this agency to subsidize existing programs that had lost state funding, rather than being used to develop new programs. In addition, they believed that the high

rate of attrition from the CHIP team was partially due to the fact that members perceived that the process was being controlled: "'I can see where this is going, so why should I bother coming? It's going to happen anyway.'"

Resources

Community C had many professional resources. A total of 26 accounting firms and 91 attorneys were listed in the phone book. In addition, there were 2 hospitals (one with 31 beds and one with 48 beds), 41 primary care physicians, 3 general surgeons, 12 long-term care facilities, and a public health department with 9 nurses and 2 nurse practitioners.

All of the respondents agreed that the community had sufficient resources to support the CHIP planning process, although one person noted that financial support for CHIP came from outside the community (from the health system that manages the hospital and from the ORH). Furthermore, most of the people who were interviewed believed that implementation of the CHIP projects would not be hindered by insufficient resources. Some of the respondents commented that financial resources had been reduced because of the recent economic downturn, yet they and others noted that the community had several funding sources to draw upon. These included local foundations, casinos, service clubs, and wealthy residents who might be willing to donate to CHIP. The health system that managed the hospitals was viewed as a primary source of support, not only for funding but also for professional services such as grant writers.

Only two people expressed concern that financial resources would hinder the team from achieving their goals. One of these individuals said that the funding that was

provided to CHIP was only enough to do a limited amount of planning so, if this wasn't adequate for some projects, their potential for implementation will be reduced. The second individual believed that, if the CHIP goals were to be achieved, a bond measure would need to be passed and, because the community-at-large was mostly uninformed about CHIP, he doubted that this could be achieved. In addition, a third person stated that the unwillingness of professionals to volunteer their time to CHIP could impede implementation.

Summary

Table 28 summarizes the factors pertaining to the physical setting and social structure of Community C. How each factor influenced participation in CHIP is summarized in Table 29.

Table 28
Description of Factors Pertaining to Physical Setting and Social Structure in Community C

Physical and Structural Factors	Description
Physical or structural barriers	Barriers included time constraints, cultural differences, lack of childcare, lack of transportation, and distance.
Civic organization and experience with social planning	There were many voluntary associations and many volunteers. This community had considerable experience in conducting health planning.
Leadership	Some viewed the leaders as weak (not inclusive or bold, lacking vision, poor problem-solvers, not interested in health); others said the leaders were strong (good management skills, thoughtful, supportive of public health). Some said the unofficial leaders were stronger than the elected leaders. Others noted that the retirees were strong leaders. Two people said that there was a group of leaders who were controlling.
Resources	Resources in all categories were sufficient to support the planning phase and most of the respondents believed that resources were sufficient for implementation as well.

Table 29

Physical and Structural Factors Influencing Participation in CHIP in Community C

Physical and Structural Factors	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Physical or structural barriers	Benefits: One respondent said that the issues that were addressed may have been different if barriers had not kept certain sectors from participating	Barriers hindered the participation of several sectors including ethnic minority populations, young working people, the low-income population, the business community, and people from the north part of the county		
Civic organization and experience with social planning	Decision-making: Having team members who were involved in other community associations was beneficial because they were aware of local needs Decision-making: Community organization meant that members knew how to gather input from constituents Decision-making: The team members' experience in doing health planning facilitated the CHIP process Implementation: Voluntary organizations had been and may continue to be a source of financial support for CHIP		Extent: The team members' experience with other health planning efforts that were successful contributed to their commitment to CHIP	
Leadership	Decision-making: The retirees with urban leadership experience facilitated decision-making and kept the process "on track" Benefits: One respondent said that, because		Extent: Some respondents said that a group of leaders who were controlling led to attrition because members believed CHIP was biased	Some respondents said that a group of leaders who were viewed as being controlling led to the perception that

	leaders were not bold, they might not support innovative CHIP strategies Implementation: Absence of leaders from CHIP team limited ability of team to secure resources needed for implementation Benefits: Some said that leaders, even though absent, would appreciate CHIP process and goals and would be supportive Benefits: The control exerted by a small group of leaders meant that CHIP funds were used to subsidize existing programs rather than to develop new programs			CHIP was being controlled
Resources	Benefits: The community obtained enough resources to meet three CHIP goals Benefits: A few respondents observed that implementation of CHIP projects could be impeded by lack of financial resources and unwillingness of professionals to donate services			

Additional Findings

This section describes additional factors in the culture or in the physical and social structure of the community that were identified by the respondents as having facilitated or hindered participation in CHIP.

Small Size

The small size of this community was reported by several people to have had a positive influence on CHIP. One respondent said that, because the community was small, the residents were more aware of the health care problems that existed in the area, such as the fact that resources were limited and that many people were uninsured. He believed that awareness of these problems led to the residents' willingness to participate in CHIP. Another respondent observed that "people know each other, and so that probably helped." She also stated, "one thing I like about living in a rural area is like, one of our projects—children's immunization—we're going to immunize every low-income kid in this county. It feels like . . . you can make an impact."

The Presence of Newcomers

One of the primary characteristics of Community C was that it was a destination for retirees and tourists, and had a large number of low-income people who worked in the tourist industry. Many of the respondents noted that the population was constantly changing.

> [The county] is pretty transient. If you look at your retiree population, everyone says, "well, they move here when they're 65 and then, as soon as . . . they get a very serious illness or something, they have to go home,

> wherever that is. To go have their kids take care of them, or a bigger hospital, or whatever. So, the retirees are coming and going. And then you have the [tourist industry] workers [who] are very transient. . . . I don't know too many people that grew up here.

As a result, the concept of newcomer vs. old-timer was not relevant here. As one person explained, "We're so used to different people. And they come from everywhere. . . . [The notion of whether someone is a newcomer or an old-timer] is not something that divides the county at all . . . " In addition, it was reported that the newcomers had brought urban values and urban experiences to this community. One person stated:

> We're not rural in the same sense that [another part of the state] is rural. These are folks, for the most part, who have spent their productive years in urban areas and bring those same values over here. They . . . no longer have all the resources that they had when they lived in [large city] or wherever, but we're not all that much different . . . Here, you have urban people now residing in a rural area.

The presence of so many newcomers meant that many of the people who participated on the CHIP team were experienced in doing social planning and, as a result, this community's participation in CHIP was described as being very similar to how it would have occurred in an urban setting. One person, who retired from a position as director of a health department in a metropolitan county, explained:

> If you were out in . . . the Midwest in a little farm community that's got a couple thousand people in it, by our standards, we'd call that rural. And

> you're quite isolated and . . . a lot of people live their whole life there. To try to apply that to a situation like ours here, even though the nature of our physical community is rural, the people in this community are highly cosmopolitan. . . . I mean, a lot of people who are here spent their life in [large city] or places like that. . . . So people bring to this community whatever their life experience is. . . . So, I guess, it goes to how much does the environment of where you are influence what you do, and how much does what people bring to the process influence it. Because I don't quite frankly see that what went on here. . . . I mean it was facilitated by some circumstances that we talked about. . . but I don't see it as all that different in terms of a process than other planning efforts that I've been involved with elsewhere.

Change in Hospital Management

Community C had two hospitals, both of which were being managed under an affiliation agreement with a corporate health system. The transition from management by the local health districts to management by the health system occurred just prior to the community's involvement in CHIP. The final affiliation agreement was signed in January 2002 and the CHIP team began meeting in September 2002.

Several respondents reported that the timing of this transition had a positive influence on participation in CHIP. One way in which it facilitated the process was through the provision of resources. It was noted that the health system administrators were willing to fund CHIP because participation in CHIP helped them to meet a

contractual obligation and provided them with information about the community. The recent transition to new management also meant that the health district board members were no longer encumbered with the responsibility of managing the hospitals and could turn their attention to broader community health concerns. As a result, three people from one of the health district boards volunteered to participate in the CHIP team. Finally, one respondent commented:

> [The recent affiliation agreement with the health system was] good timing because [CHIP] . . . was kind of sold as their project. They didn't have a long history so people didn't feel positive or negative about them. I thought . . . it was pretty perfect timing. You know, if they had been around awhile and there were hard feeling about something, people might have said, "no, I'm not going to participate."

Recent Funding Cuts

The CHIP process in this community began during a time when severe cutbacks in state funding for human services were occurring. Several people noted that this had a significant effect on participation in CHIP. One person explained that the budget crisis meant that many human service personnel viewed CHIP as a low priority and so chose not to participate in the team meetings.

> The initial meeting occurred at a time when we were getting devastating information about budgets, state cuts, local cuts. And to engage in a process that would take you away from your day to day, that didn't . . . it had $50,000 attached to it, but that was it. I think that there was some

> people that never returned to the process because they felt like, “we're in shambles; why would we be doing community visioning and processing when . . .our arms and legs are being cut off.” . . . So I think that there were some people that initially felt like they couldn't afford the time, that . . . didn't want to put their energies into community visioning.

Others reported that conflict emerged during the meetings because of the tensions associated with the budget cuts. For example, one person said:

> One thing that I think you need to note on this, this CHIP group was meeting under some very severe societal pressure as it was during the time when all the budgets were being cut. So you had everybody in that room that had anything to do with social service background . . . I mean, we were almost at each other’s throats at times to sustain what we had. . . . The timing was very difficult so it doesn't reflect necessarily . . . ordinary circumstances.

Finally, several people observed that the outcomes of CHIP were also affected by the reductions in funding for human services. It was noted that, due to the loss of state funding, some of the county public health programs were slated for elimination. The public health administrators appealed to the CHIP team for funding and the team members agreed to allocate a large portion of their funds to these programs. For the most part, the respondents accepted this as something that had happened but wasn’t necessarily detrimental. When one person was asked whether the recent cuts in state funding meant that the timing for CHIP was bad, she said:

> I don't think it was bad timing. I think it affected the outcome. I don't think if the health department hadn't been cut that we would have been funding immunizations and prenatal care. . . school-based health centers. I suspect we would have done something else. . . . And, I think, if it had been a different time, maybe we would have done more new projects. But it was the reality and I think it was good for the community. I'm glad we're going to immunize kids and have prenatal care! But it affected it, it affected it.

However, two people expressed disappointment in the outcomes. One stated, "When I came on board, I was thinking more of community benefits. . . . [But] actually, there was no community benefit. It was all subsidizing the state programs." And another said, "[It was] essentially business as usual . . . it wasn't really creating anything new. It was funding things that didn't get funded."

Summary

Four additional community characteristics were mentioned by respondents as having an influence on participation in CHIP. These are summarized in Table 30.

Table 30
Factors Outside of the Conceptual Model That Influenced Participation in Community C

Community Characteristic	What Kind of Participation	Who Participated	How Did Participation Occur	Perception of the Process
Small size			Extent: Small size meant residents were more aware of health care problems and this led to their willingness to participate Effect: Small size meant that team members felt they could have an impact	Team members familiarity with each other facilitated the process
Presence of newcomers	Decision-making: The team members' experience in social planning facilitated the CHIP process			The involvement of newcomers in CHIP meant that this process was similar to how it would have occurred in an urban setting
Change in hospital management	Implementation: The recent affiliation agreement prompted health system to provide resources to CHIP		Extent: Recent affiliation agreement prompted health district board members to participate in CHIP Extent: The fact that the community's relationship with the health system was new meant that people had no biases that might have prevented them from participating	
Recent funding cuts	Benefits: Due to recent funding cuts, a high proportion of CHIP funds were used to sustain existing programs		Effect: Funding cuts meant that many human service personnel viewed CHIP as a low priority Extent: Funding cuts led many human service personnel to drop out of CHIP	Tensions associated with recent funding cuts resulted in competition for CHIP dollars and conflict during meetings

CHAPTER VIII

CROSS-CASE COMPARISONS

The purpose of this chapter is to describe the results of the cross-case analysis of participation in CHIP. Four sections are included. The first section briefly compares the communities on several dimensions pertinent to rurality. The second section describes how participation was enacted across the communities. The third section focuses on the factors that are part of the study's conceptual framework and presents the findings relevant to the study propositions. The final section describes community characteristics outside of the conceptual framework that were identified by respondents in more than one community as having an influence on participation.

Comparison of the Communities

All of the communities that were included in this study were considered to be rural based upon the definition that was provided in Chapter 3, yet they differed in terms of several key physical and demographic characteristics. A comparison of the communities is found in Table 31.

Table 31
Comparison of Communities on Selected Characteristics

Community Characteristic	Community A	Community B	Community C
Size[1]	7641 residents with one main town, population 4230; population of area was declining	14,266 residents with one main town, population 9840; population of area was increasing	44,479 residents with two main towns, population 9532 & 5903; population of area was increasing
Proximity to metropolitan area[2]	82 miles from city of 50,000+ residents	129 miles from city of 50,000+ residents	Town C1 was 57 miles from a city of 50,000+ residents and 90 miles from city of over 500,000; Town C2 was 55 miles from a city of 50,000+ residents
Primary industry[3]	Economy was in transition; health, education, social services were primary employers; forestry and fishing had declined	Health, education, social services were primary employers in Town B1; agriculture was a major industry outside of Town B1; wood products manufacturing had replaced logging	Tourism was primary employer in towns located on the coast; forestry was primary employer in the inland region but this was declining
Median age[4]	47.3 years	45 years	44 years
Percent below poverty[4]	15.8%	14.4%	13.9%
Average unemployment rate[4]	9%	8.8%	6.9%

Note. [1]ORH, 2003; PSU, 2002; [2]MapPoint (retrieved September 1, 2003 from the World Wide Web: http://mappoint.msn.com); [3]U.S. Census, 2000; [4]ORH, 2003.

Of the three study sites, Community A had the fewest residents and the smallest main town, whereas Community C had the most residents and had two main towns. Community A had a declining population, the highest percentage of residents that were poor or unemployed, the oldest population, and an economy that was in a state of transition. In contrast, Community C had a growing population, the lowest percentage of poverty and unemployment, the youngest population (despite being a destination for retirees), and a stable economy based on tourism. Community B was the most isolated of the three communities. It was farthest from a city with a population of 50,000 or more and was surrounded by miles of agricultural and forestland. However, Community A was also quite isolated with very small neighboring towns and much open forestland. Community C was the least isolated. It was less than 60 miles from a major metropolitan corridor and was a weekend or vacation retreat for many city dwellers.

How Participation Was Enacted

The cross-case analysis identified similarities and differences in the patterns of participation across communities. Some of the similarities were a result of the structure of the CHIP process. However, participation was also similar among communities in ways that were not related to the structure of CHIP. In addition, many differences were noted in how participation was enacted across sites. The patterns of participation across communities are described in this section. Table 32 provides a summary of these findings.

Table 32
Similarities and Differences in How Participation was Enacted Across Communities

Dimension of Participation	Similarities Due to CHIP Structure	Similarities Not Due to Structure	Differences Between Communities
What Kind of Participation Occurred			
Participation in Decision-making	• The decision-making process • The role of team members in decision-making • Perception of team members' control over decision-making		• The influence of team members' agendas on decision-making • Degree of comfort with decision-making, particularly among team members representing non-health sectors
Participation in Implementation	• The resources contributed by the community		• Sources of funding for program planning and implementation
Participation in Benefits	• The number of "issues" or problem areas that were addressed • Inclusion of strategies for health promotion as well as strategies to expand health services • Range of complexity of CHIP projects • Intangible benefits were similar across communities		• CHIP goals focused on sustaining existing programs vs. developing new programs
Who Participated	• The CHIP team included representation from non-health sectors of the community • Team members made some effort to obtain input from diverse populations • Attendance at CHIP community meetings was similar across communities	• The CHIP team members were predominately White, middle-class women; no youth participated	• The presence of community leaders on the CHIP team • The involvement of retirees on the CHIP team • The percentage of team members representing the health sector

How did Participation Occur The Basis of Participation			• Where the impetus for participation originated • The hospital's rationale for participation in CHIP • The organization that sponsored CHIP
The Form of Participation		• "Consumers" or members of vulnerable groups did not participate directly but were represented by advocates or human service agency personnel	• The coordinator's criteria for selecting CHIP team members
The Extent of Participation			• Attendance at CHIP team meetings • Attrition of CHIP team members • Commitment of team members to remain engaged after the CHIP planning phase ended
The Effect of Participation		• The community-at-large would be unlikely to perceive CHIP as being worthwhile at this time	• Team members' perception of CHIP as being worthwhile

Similarities in Participation That Were Due to the Structure of CHIP

The structure of the CHIP process resulted in similarities across communities in the quantitative dimensions of participation. These included similarities in the extent of community participation in decision-making, implementation, and benefits, as well as similarities in who participated.

Participation in decision-making. All of the communities received training in the CHIP process from the ORH and followed the steps for decision-making that are outlined in the CHIP manual. In addition, all received similar data and decision-making tools to support their planning process. Within this framework of support, the CHIP team members were responsible for identifying local needs, setting priorities, and planning interventions. Because the ORH only facilitated the process and did not take part in making decisions, the majority of respondents in all of the communities believed that the team members had full control over decision-making. A few people noted, however, that the decisions were constrained to some extent by the data they were given and the methods they used for determining priorities.

Participation in implementation. The ORH requires that communities participating in CHIP provide half of the salary for the CHIP coordinator, as well as office space, meeting space, and equipment and supplies. In addition, the communities must furnish labor in the form of people who serve on the CHIP partnership team. Because of these requirements, the resources that were contributed by each community to support the planning process were very similar across communities.

Participation in benefits. Although the team members had considerable control over decision-making, the CHIP process imposed some structure on the number and type of projects that were planned. The ORH Community Services Manager explained that, because communities have a tendency to limit their focus to health resource concerns (i.e., buildings and manpower), a decision-making tool is employed to prompt the CHIP team members to address health status concerns as well (personal communication, P. McGinnis, March 5, 2004). The team members in each community used this tool, a matrix, to select three priority health resource issues and three priority health status issues. The ORH recommended that six issues be selected because, in their experience, this is a number that is manageable for small communities. In addition, team members were coached to choose projects of varying levels of difficulty so that the chance for success in at least a few areas is increased. As a result of this structure, the outcomes of CHIP were similar across communities in that each community targeted four to six areas of concern, each developed some strategies for improving community wellness, and each included some projects that were relatively simple as well as some that were quite complex.

Some of the similarities in the intangible benefits that were reported were also related to the structure of CHIP. For example, respondents in each of the communities noted that, because of their participation in CHIP, community members gained a greater awareness of health concerns and of available health resources. This benefit is actually an aim of CHIP and is part of the process (McGinnis, 1999). Also, stronger social

networks were reported in two of the communities. This intangible benefit was derived from the diversity of representation on the CHIP team that is a requirement of CHIP.

Who participated. The CHIP guidelines specify that team members are recruited from a variety of community sectors, therefore each team included some people from sectors other than health care. The guidelines also encourage team members to seek input from residents of various ages, genders, ethnic backgrounds, and the like, thus all of the teams made an effort to gather information from diverse segments of their population. In addition, because all of the teams followed the same steps in inviting people to the CHIP community meeting, the meetings were attended by a similar number of residents in each community.

Similarities in Participation That Were Not Due to the Structure of CHIP.

In addition to the similarities just reported, the communities also shared certain patterns of participation that did not seem to be linked to the structure of CHIP. These included similarities in who participated, the form of participation, and the effect of participation.

Who participated. Although the CHIP coordinators made an effort to recruit team members from a variety of community sectors, the members of each CHIP team were predominately White, middle-class women. Only 21—33% of the team members were male, 0—5% represented an ethnic minority group, and none represented the low-income population. In addition, none of the teams included youth (i.e., people under 20 years of age).

The form of participation. The communities were also similar in the manner by which "at-risk populations" were represented on the CHIP team. Respondents in each of the communities reported that "consumers" did not participate directly in the team but were represented by advocates or human service agency personnel. (However, some effort was made to survey members of at-risk populations or to invite them to the CHIP community meeting.)

The effect of participation. In each of the communities, respondents reported that the public-at-large would, at this time, be unlikely to perceive CHIP as worthwhile. The primary reason given for this was that residents were waiting to see the results before deciding if the process had been valuable. Because many goals had not yet been achieved, and those that had been achieved had not been widely reported, most respondents doubted that the public would view CHIP as being worthwhile.

Differences in How Participation Was Enacted Across Communities

Despite significant similarities in the pattern of participation across the communities, many differences were also observed. In fact, some differences between communities were noted for every dimension of participation.

Participation in decision-making. One difference between the communities concerned the impact of team members' agendas on decision-making. In Community C, many of the people who participated in the CHIP team meetings came with "agendas," seeking support or funding for their organization or cause. While some of the respondents believed that the process had been fair despite these agendas, others

perceived that decision-making was biased. This phenomenon was not reported in either of the other communities.

Another possible difference among the communities pertained to the team members' comfort with the decision-making responsibility. In Communities A and C, nearly all of the respondents said that the CHIP team members were comfortable in decision-making. However, in Community B, the respondents' comments cast doubt on whether the team members who represented non-health sectors of the community were comfortable in decision-making. While the coordinator and the respondents who represented the health sector said that all team members were comfortable, the two respondents who represented non-health sectors said that they were not. One person said that he was unable to contribute much to the planning discussions because his knowledge of health care was limited. Another stated that she was not able to effectively participate because she "didn't speak their lingo." Unfortunately, none of the other team members who represented the non-health sectors participated in this study and so the support for this conclusion was limited.

Participation in implementation. The communities differed in regard to which agencies contributed resources to CHIP and whether funding came from within the community or from outside sources. In Community A, the hospital was the primary contributor, providing funding for the coordinator's salary as well as office space, equipment, and supplies. After the CHIP plan was complete, the hospital also agreed to match the grant received from the ORH to support project implementation. In Community B, the hospital and the county both contributed funds for the coordinator's

salary and office expenses, but funds for project implementation had been obtained from sources outside of the county (from the ORH and from the health system that owns the hospital). In Community C, the funds to support the coordinator's salary came from outside the community, from the corporate health system that manages the county's hospitals, although office support was provided by the local health districts. A high percentage of the grants that have been received for project implementation in this community have come from local foundations.

Participation in benefits. The main difference among the communities in terms of the benefits they received from their participation in CHIP was that Community C chose to sustain several existing public health programs, whereas Communities A and B focused on developing new projects to address unmet health needs. The plan that was developed in Community C did include several new projects. However, the primary goal of this community's CHIP team was to offset reductions in state funding for three existing child health programs.

Who participated. The composition of the CHIP teams varied across communities in terms of the involvement of community leaders, the involvement of active retirees, and the proportion of members representing the health care sector. The Community A CHIP team consisted largely of local leaders (i.e., people who were in positions of authority in their organizations). Most of the participants were middle-aged, working people; 33% represented the health care sector. The Community B CHIP team included no elected officials and very few leaders in general. The majority of the members were middle-aged, working people who represented a cross-section of the

community; 38% represented the health care sector; many were from the remote regions of the county. In Community C, 58% of the active members (i.e., members of the core team) were health care professionals and the number of active retirees who participated in the team nearly equaled the number of middle-aged people. There were no elected officials on the team and most of the team members, although active in their organizations or sectors, were not considered to be the community leaders.

The basis of participation. Some differences were noted among the communities in terms of where the impetus for participation originated, the hospital's rationale for participation, and what agency sponsored CHIP. In Communities A and C, the hospital or health care system approached the ORH and requested to participate in CHIP whereas, in Community B, the ORH recommended the CHIP program to the hospital. The Community A hospital wanted to expand its mission and demonstrate an interest in community health. The Community B hospital viewed CHIP as a resource for survival and to improve its relationship with the community. In Community C, a contractual obligation between the corporate health system and the local health districts prompted the health system to become involved in CHIP. The hospital in Community A served as the sponsoring organization for that community's CHIP project, a county department agreed to sponsor CHIP in Community B, and the corporate health system sponsored CHIP in Community C.

The form of participation. The primary difference among the communities in the form of participation was in the criteria that the CHIP coordinators used for selecting CHIP team members. All of the coordinators sought to recruit members from diverse

community sectors. However, in addition, the coordinator in Community A made an effort to recruit leaders, people who were in positions of authority and could "make things happen". The coordinator in Community B invited people she knew or had connections with, mainly from the outlying regions of the county. Her goal appeared to be to assure that residents of the remote sections of the county had a voice in CHIP. The coordinator in Community C chose to recruit people who were active within their sector although, unlike the coordinator in Community A, she did not make an effort to invite agency administrators or others in positions of authority.

The extent of participation. The communities varied greatly in terms of the commitment of the team members to CHIP. In Community A, attendance at CHIP team meetings was good and there was very little attrition. After the planning phase ended, many of the team members volunteered to participate in a task force to oversee implementation of the CHIP projects. In Community B, attendance was sporadic and attrition occurred, particularly among the members who represented non-health sectors of the community. All of the people who represented the non-health sectors, except for the coordinator, stopped participating in CHIP when the planning phase was complete. The CHIP team remained active in this community but was dominated by health care providers, mainly hospital personnel. In Community C, less than half of the CHIP team members were active and attrition was very high. Many people dropped out early in the process. At the time of this study, some of the CHIP goals were being pursued by a small number of CHIP members, but most of the members were no longer active. The

coordinator intended to reconvene the team at a later date but many of the respondents were unaware of this and thought that the process had concluded.

The effect of participation. The team members' perceptions of whether CHIP was worthwhile varied considerably across the communities. In Community A, the majority of the respondents said that they and other team members were pleased with what had been accomplished. In Community B, it was noted that the team members who represented the non-health sectors of the community lost interest in the process but that the health providers who were still participating in CHIP viewed it as being important. Finally, in Community C, some of the team members did not perceive CHIP as a priority or were dissatisfied with the goals and so dropped out of the team. Of those who remained committed to the CHIP process, most perceived it as being worthwhile but a few were disappointed in the outcomes.

Cross-Case Comparisons on Factors from the Conceptual Model

This section presents the cross-case findings relevant to the study's propositions. The communities are briefly described and compared on each of the eight factors, or characteristics, that were part of the conceptual framework. In addition, the primary themes concerning how each characteristic influenced participation in CHIP are presented.

Priority Given to Health

The findings from this study did not support the proposition that rural communities prioritize health needs as secondary to economic needs and that this hinders their participation in a health development initiative. Instead, the data showed that the

priority given to health in rural communities was higher than anticipated and that participation was influenced in either a positive or negative way by residents' concern or lack of concern about the health care system.

The respondents across communities were divided in their opinions concerning the priority given to health in comparison to economic needs. While some said that health was not as important as economic development or other issues, approximately half of the people who were interviewed in each community reported that health was one of their community's top concerns. Those who believed that health was a high priority said that this was due to the growing number of elderly residents, which, in part, was a result of an influx of retirees. It was noted that, for older people, health is an important concern. Thus, as the communities have aged, the priority given to health has increased.

Health promotion, however, did not appear to be of great interest to the rural residents. When respondents were asked to describe their community's major health-related concern, their most common response was access to care. Health promotion and disease prevention were not cited as being community concerns in any of the study sites. In fact, in Community A, some of the respondents explained that health promotion was considered to be a personal matter and not something that others should address.

The degree to which residents were concerned about health services was found to have an effect on participation in CHIP. In Community A, it was reported that the residents' fear of losing their hospital provided a strong incentive for many to participate in CHIP. In Community B, some respondents noted that the residents' dissatisfaction with local health services and concerns about the broader health care system (i.e., health

care costs and insufficient insurance coverage) prompted people to participate initially. However, others observed that the attrition of team members who represented the non-health sectors was due to the fact that health was not a high priority for most residents. Similarly, in Community C, the few people who commented on this issue said that the high proportion of health providers on the CHIP team reflected the fact that they, unlike the community-at-large, had an interest in health matters.

The low interest in health promotion emerged as a possible reason that some respondents in Community A viewed the CHIP wellness goals as insignificant, but this relationship was not identified in the other communities. In fact, other respondents in Communities A and B stated that one of the benefits their community received as a result of their participation in CHIP was that residents' gained a greater awareness of health matters, including the importance of health promotion.

Perceived Efficacy of Collective Action

The proposition that participation is facilitated because rural residents have confidence in their collective ability to solve community problems was partially supported by the findings. The perceived efficacy of collective action varied across the communities, but where it was strong, it had a positive influence on participation. On the other hand, rural residents were skeptical about their ability to bring about health improvements and this skepticism had both a positive and a negative effect on participation.

The residents' confidence about making general community improvements appeared to be strongest in Community A and weakest in Community C. Most of the

respondents in Community A reported that residents believed they had the collective ability to bring about positive change, whereas the respondents in Community C were divided in their opinions, with approximately half stating that residents were not positive about collective action. Interestingly, Community A was the smallest and most economically depressed of three communities and was isolated, whereas Community C was the largest, wealthiest, and least isolated community. The perception concerning collective action in Community B was similar to that in Community A. The majority of the respondents in this site reported that at least some, and possibly most, of the residents believe they have the ability to improve the community.

In contrast to the variation in the perceptions concerning collective action in general, the communities were similar in regard to residents' confidence in their ability to make health improvements. In each community, residents were generally skeptical about their ability to improve health, although some were willing to try. The skepticism was attributed to lack of experience in making health improvements, the failure of other social programs, and the complexity and magnitude of rural health care problems.

The residents' overall confidence in collective action had a positive influence on participation in CHIP in Communities A and B. Respondents in these communities reported that collective efficacy contributed to the residents' commitment to CHIP and their willingness to seek solutions to challenging problems. At the same time, the skepticism about making health improvements was found to have a significant effect on participation in Communities A and C, although the impact was different in each of these communities. In Community A, the community's skepticism was linked to a strong sense

of urgency among CHIP team members to "show results" to prove to the residents that health improvements were possible. Although this created tension, it did not hinder participation but facilitated participation by strengthening the team members' resolve. In Community C, the effect was negative; it contributed to the attrition of CHIP team members, particularly those who represented non-health sectors.

Insider vs. Outsider Differentiation

This study did not find general support for the proposition that participation of a rural community in a health development initiative is facilitated if the person who is leading the initiative is an "insider." Instead, both insider and outsider status can be a benefit or a hindrance to community participation.

Each of the communities in this study had leaders who were known to some residents and unknown to others. Community A had two leaders, the CHIP coordinator and the CHIP chairperson, both of who were new to the community. The coordinator was unknown prior to CHIP, but the chairperson held a public position, was very well known, and had close ties to other community leaders. Most of the respondents in Community B identified only one leader, the CHIP coordinator. This individual was well known in the outlying parts of the county due to her connections to people employed in agriculture, but was unknown to most residents of Town B1. In Community C, both the CHIP coordinator and the ORH staff member were identified as being the CHIP leaders. The coordinator was from the community and was well known to many of the CHIP team members. The ORH staff member was from a large city, outside the county and was known to just a few of the respondents prior to their involvement in CHIP.

In contrast to the assumption that the involvement of a leader who is an outsider would hinder participation, some residents viewed an unknown leader as being an asset. One theme that emerged in all of the communities was that having an unknown leader had facilitated participation in CHIP because it allowed the process to be perceived as unbiased. At the same time, a small but adamant group of respondents in each community reported that having a leader who was unknown had a negative effect on participation. According to these individuals, unfamiliarity with the leader resulted in decreased trust, an unsatisfactory experience, limited support for CHIP, a high rate of attrition, and the team members' refusal to consider the statistical data when identifying priority health concerns.

The leaders' status as an insider was reported to have a strong positive effect on participation in only one of the study sites. Several respondents from Community B observed that the coordinator's familiarity with residents from the outlying regions of the county had been important in recruiting representatives from these areas to the CHIP team. In Community C, most of the people who were interviewed noted that their coordinator's familiarity with residents and with the community had been helpful but not essential to the CHIP planning process. In Community A, respondents observed that whether the coordinator of CHIP was an insider or an outsider was less important than leadership skills and the ability to work with and listen to established community leaders. In addition, the comments of two respondents suggested that having a leader who was known had actually been a hindrance. They noted that the CHIP chairperson's

connections with other local leaders gave the impression that the planning process had been manipulated or controlled.

Sense of Community and Commitment to Community

The proposition that participation of rural communities in a health development initiative is facilitated because of a strong sense of community and commitment to community was partially affirmed. The rural towns were characterized by a strong sense of community and this had a positive influence on participation. However, the commitment to community was found to be variable and its effect on participation was less certain. Where it was strong, it appeared to facilitate participation and, conversely, where it was weak, it appeared to be a hindrance.

Residents in each of the individual towns, with the exception of Town C1, felt a strong sense of connection to each other and to the community and were willing to help each other. However, the sense of connection was not strong across the towns that made up each CHIP community. Respondents in each study site noted that there were divisions among towns or regions within their CHIP community and that long-standing resentments or rivalries existed.

Responses concerning the commitment to community varied. In Community C, the respondents reported a high level of volunteerism, especially among the retirees. Similarly, most of the people who were interviewed in Community B said that the commitment to community was strong, although a few noted that a segment of the population was reluctant to work on behalf of the community. However, in Community A, respondents were divided in their opinions concerning the commitment to community.

Half said that there were many volunteers, while the other half reported that the same people do everything.

The strong sense of community within individual towns or regions appeared to have a positive effect on participation in CHIP. Many of the respondents, especially in Communities A and B, reported that the sense of community contributed to the willingness of residents to participate, the perception of CHIP as being important, the diversity of people involved, and the team members' commitment to the process. On the other hand, the divisions among regions within the CHIP communities were found to have little effect on participation. A small number of people stated that the divisions had kept certain groups from participating or had created conflict, while others noted that CHIP had been beneficial in bringing the regions together.

Only a few people believed that the commitment to community had influenced participation in CHIP. In Communities A and B, a small number of respondents stated that the limited commitment to community was reflected in team member burnout, attrition, and reduced input from the community-at-large into decision-making. In Community C, those who commented on this issue said that high percentage of retirees on their CHIP team was a reflection of the fact that, for active retirees, participation in CHIP was "just a natural thing . . . just another, you know, one more volunteer thing to do."

Physical or Structural Barriers

The proposition that rurality presents barriers that make it difficult to achieve broad-based participation in a health development initiative was found to be true.

However, whether the limited diversity of participation in CHIP had an impact on the decision-making process or the outcomes is uncertain.

Several physical or structural barriers to participation were identified in each of the study sites. Those that occurred across all of the communities were time constraints, distance, and lack of transportation, with time constraints being the barrier that was mentioned most frequently. Some of the respondents in Communities A and B also described psychological or interpersonal barriers that they believed had hindered participation in CHIP. These included not being invited, not feeling comfortable at the CHIP meetings, having conflicting personal priorities, and having concerns that were not shared or understood by the team members.

Time constraints were identified as a primary reason for absenteeism or attrition of CHIP team members. It was also noted that barriers impeded the involvement of at-risk populations, although most of the people who were interviewed did not believe that this had ultimately hindered the planning process. They explained that the CHIP team included advocates and employees of human service agencies who represented the concerns of sectors that were missing. However, at least one person in each community said that the decisions that were made or the goals that were chosen might have been different if "consumers" had participated.

Civic Organization and Experience with Social Planning

The data did not support the proposition that participation is hindered in rural communities because of few civic or grassroots associations and limited experience with social planning. The study communities had many active voluntary organizations

including civic groups, church and school groups, and associations focused on economic development. These were generally described as popular and well attended, except in Community A, where several respondents observed that the same people belonged to many of the groups and that membership tended to be small. However, few of the respondents believed that the presence of active voluntary organizations had an effect on their community's participation in CHIP. The small number that did report an association said that civic organization had facilitated participation. They noted that the CHIP team members' involvement in voluntary groups had given them experience in organizing community events and enabled them to be aware of community needs and gaps in services. One person in Community C noted that civic groups and churches had been and were likely to be a source of financial support for the CHIP projects.

The assumption that rural communities have limited experience with social planning was found to be generally true in Communities A and B, but not in Community C. The respondents in Communities A and B reported that their communities had engaged in some planning efforts, mainly related to economic development, but had very little experience with health planning. In addition, many stated that the outcomes of previous planning efforts had been insignificant or that few residents were aware of the results. These respondents did not believe that their community's limited experience and success in planning had hindered CHIP, however. The majority saw no relationship between the history of planning and participation, although a small number suggested that the limited experience and success in planning contributed to skepticism concerning CHIP. On the other hand, the respondents in Community C observed that their

community has participated in much health planning, including complex regional or statewide efforts, and that the results have been largely successful. They reported that this history had a positive effect on CHIP in terms of the team members' willingness to commit to the process and the team members' comfort and skill in decision-making. (As was noted in the Community C case description, however, at least some of the team members acquired their experience in planning prior to moving to this community.)

Leadership

This study found little support for the proposition that rural community participation in a health development initiative is hindered because of the lack of effective leadership. Instead, it found that the rural communities had capable leaders and that involvement, or lack of involvement, of leaders on the CHIP team had a greater influence on participation than did the strengths or weaknesses of leadership in the community.

The respondents in each of the study sites reported that their community had some leaders who were ineffective or resistant to change and others who were competent, collaborative, and innovative. While there was a tendency for the respondents to describe the elected leaders as being weak and the non-elected leaders, such as hospital managers and agency administrators, as being strong, this was not entirely consistent.

A few people in each community noted that the weaknesses of the leaders had hindered participation in CHIP. They observed, for example, that the leaders who were conservative, cautious, and resistant to change had attempted, or might attempt, to impede implementation of the CHIP projects. In Communities A and C, a few

respondents stated that leaders who were controlling and non-inclusive had controlled the CHIP agenda and, in one case, had manipulated the outcomes to serve their interests. The majority of the respondents, however, did not believe that participation was hindered by ineffective leadership. On the other hand, one respondent in Community B observed that the presence of knowledgeable and skilled leaders in their community made it possible for their CHIP team to maintain operations and to achieve challenging goals after the support from the ORH ended.

The presence or absence of leaders on the CHIP team, although not a community characteristic, was reported to have a significant influence on participation. The Community A CHIP team included many strong local leaders, and several respondents noted that their involvement contributed to the team members' commitment and investment, confidence in decision-making, a satisfying group process, and a strong potential to achieve their goals. The CHIP team in Community B included very few leaders and some respondents believed that this led to weak decision-making, an unsatisfactory group process, and attrition of team members. The Community C CHIP team included many retirees who had leadership skills, but few official leaders. In this community, some of the respondents expressed concern that the CHIP goals would be unattainable because the people who have access to or control over resources did not participate in the team. Yet others noted that the planning process had been facilitated because of the skills and knowledge that the retirees brought to the team.

Resources

The proposition that rural community participation in a health development initiative would be hindered because of limited professional, technical, and financial resources was not found to be true, although it might prove to be true in at least one community over time. This study found that participation in CHIP was not hindered in any of the communities because of limited resources. However, this finding was influenced by the structure of the CHIP process, which requires that communities set aside certain resources to support the process before engaging in CHIP, and by the fact that the ORH contributed half of the funds needed for the coordinator's salary.

Because the study was conducted within a few weeks after Communities A and C had developed their CHIP plan, it was too soon to know whether implementation of the projects would be impeded by lack of resources in these communities. Community C had, however, already obtained enough resources to implement three of the CHIP goals and the majority of the respondents noted that the community had many resources to draw from to support implementation of the remaining projects. In contrast to this observation, several respondents in Community A expressed concern about the shortage of financial resources. They noted that the community has few sources of funding other than the hospital. The Community B CHIP team had completed its planning phase approximately 18 months prior to this study and had gradually made progress in achieving their goals. Some of the respondents commented that delays in receiving funding had slowed implementation, but this was the only hindrance reported. The respondents who were still active in the CHIP team expressed confidence in being able to

access resources, noting that grants had been received and that other sources of support had not yet been tapped.

Cross-Case Comparisons on Factors Outside the Conceptual Model

This section presents additional factors, outside of the conceptual model, that were mentioned by respondents in more than one community as having an influence on community participation in CHIP. These factors included (a) small size, (b) the presence of newcomers, and (c) the perception of the hospital.

Small Size

The community's small size emerged as a factor that influenced participation in Communities A and C. The effect of small size on participation was primarily described as being positive, although some respondents reported that small size had hindered participation. It was noted that, in a small community, residents were aware of their neighbor's health-related needs and of problems pertaining to the local health care system. Respondents observed that, because the residents were aware of the needs, they were motivated to participate in CHIP. In addition, the residents' knowledge of the community and its needs meant that assessment and identification of problems was relatively easy. The respondents also reported that the residents' familiarity with each other enhanced the perception of credibility and trust among the team members. One person also observed that the small size of the community meant that the CHIP projects were able to reach everyone; thus, the process had a greater impact on health than might have been true in an urban environment.

In contrast to these observations, two respondents in Community A noted that the lack of anonymity that was associated with living in a small community had a negative effect on participation in CHIP. One person explained that, because the team members interacted regularly in many settings, they were uncomfortable in expressing opinions that conflicted with those of others and this, in turn, reduced the honesty and openness of team discussions. Similarly, the second individual, an employee of a human service agency, commented that agency personnel who participated in CHIP were more vulnerable than they would have been in an urban setting. She noted that because the rural agencies were small, the employees were seen as being the agency, whereas employees of large urban organizations would have more protection.

The Presence of Newcomers

The presence of newcomers was also cited as having an influence on participation in Communities A and C. Respondents in Community C described the population of their community as being comprised of many newcomers, particularly retirees who had moved to this area from urban places and people who came to work in the tourist industry. Many of the CHIP team members had urban experience in social planning and, as a result, they were comfortable and competent in decision-making. In fact, it was observed that the planning process that occurred in Community C was no different than it would have been if it had occurred in an urban area because the people involved were individuals with urban experience.

The respondents in Community A reported that their community was also attracting newcomers, including retirees, although not to the same extent as Community

C. The newcomers who participated in the CHIP team were aware of what other communities had done to improve health and that these ideas contributed to the creativity of the outcomes. In addition, several people noted that the newcomers brought enthusiasm to the process, unlike the old-timers who were resistant to change.

The Perception of the Hospital

Participation was facilitated in communities where CHIP was associated with the hospital and the residents' perception of the hospital was positive. Perception of the hospital appeared to be related to, yet distinct from, concern about health care services. In Community A, respondents pointed out that residents not only feared that their hospital might close and that services would be lost, but were also very proud of their hospital. For this reason, programs that were associated with the hospital, including CHIP, were perceived as important. Likewise, in Community C, the fact that most residents were cautiously optimistic about the new corporate health system contributed to their willingness to participate and may have also contributed to their optimism concerning CHIP. For example, several people identified the health system as being a significant resource for implementing the CHIP projects.

The impact of a poor perception of the hospital on participation in CHIP was not clear. In Community B, several people commented that hospital had a very poor reputation among residents and, for this reason, a county agency was chosen to sponsor CHIP. However, whether this had a further effect on participation is uncertain.

Summary

The purpose of this study was to describe the influence of rurality on community participation in a health development initiative. In addition to describing how participation in CHIP was enacted in three rural communities, this chapter identified factors in the culture and in the physical and social structure of the communities that influenced participation. The factors that were found to facilitate participation were a high priority given to health, perception of efficacy concerning collective action in general, strong sense of community within towns, strong commitment to community, civic organization, experience and success in social planning, effective leadership, adequacy of resources, and presence of newcomers. The factors that were found to hinder participation were a low priority given to health, weak sense of community among towns, weak commitment to community, barriers (physical, structural, interpersonal, and psychological), and ineffective leadership. Finally, this study revealed several community characteristics that had a variable effect on participation. These included perception of efficacy concerning collective actions to improve health, insider vs. outsider differentiation, perception of hospital, and small size of the community. Table 33 provides a summary of the cross-case findings. The final chapter of this dissertation discusses the implications of these findings and presents recommendations for practice and research.

Table 33
The Influence of Community Characteristics on Participation in CHIP

Community Characteristic	Effect on Participation
Cultural Factors That Facilitated Participation	
• High priority given to health	• Residents' concerns about the health care system (specifically, fear of losing their hospital, dissatisfaction with local health services, and concern about health care costs and insufficient insurance coverage) motivated them to participate
• Perception of efficacy concerning collective action in general	• Confidence in collective action prompted people to participate and to remain committed to the CHIP process • Residents' optimism about their ability to improve the community contributed to their willingness to seek solutions to complex problems
• Strong sense of community within towns	• Strong sense of community contributed to residents' willingness to participate • Strong sense of community enhanced team member commitment • Strong sense of community meant that residents viewed CHIP as important • Diversity of people involved in CHIP was linked to strong sense of community
• Commitment to community	• The willingness of retirees to participate in CHIP was attributed to their commitment to community (but might, instead, reflect a desire to stay busy)
Cultural Factors That Hindered Participation:	
• Low priority given to health	• A low priority given to health reduced diversity of the CHIP team; most were from the health sector • A low priority given to health led to attrition of team members representing non-health sectors • A low priority given to health meant that few people, other than those in health sector, viewed CHIP as important • A low interest in health promotion meant that CHIP wellness goals were viewed as insignificant by some
• Divisions within community	• Divisions among towns or sub-groups meant that some sectors did not participate • Divisions among towns led to conflict during a team meeting

• Weak commitment to community	• Weak commitment to community reduced diversity of input into decision-making • Weak commitment to community contributed to attrition of team members • The fact that the same people do everything led to team member burnout
Cultural Factors That Had a Variable Effect on Participation:	
• Perception of efficacy concerning collective actions to improve health	• Skepticism about making health improvements contributed to team members' resolve to "show results" • Skepticism about making health improvements led to attrition of team members
• Insider *vs.* outsider differentiation	• Having an unknown leader meant process was perceived as unbiased • Having a unknown leader led to distrust and dissatisfaction for some members • Having a leader who was known to residents of outlying communities facilitated recruitment of team members from these areas • Having a leader who was an insider was helpful but not essential to the process • A leader who was known (and was closely connected) to others in the community contributed to the perception that CHIP was manipulated
• Perception of hospital	• Residents' optimism about hospital led to optimism about CHIP • Residents' esteem for the hospital meant that CHIP was viewed as important • Residents' poor perception of hospital contributed to decision to disassociate CHIP from the hospital
Factors in the Physical & Social Structure That Facilitated Participation:	
• Civic organization (active voluntary associations)	• Team members' involvement in voluntary associations gave them organizational skills which facilitated data-gathering & program planning • Team members' involvement in voluntary associations was beneficial because they were aware of local needs • Voluntary organizations have been and will be a source of financial support for CHIP projects

• Experience and success in social planning	• Team members' prior experience in social planning contributed to comfort & skill in decision-making • Team members' experience with previous planning efforts that were successful contributed to their commitment to CHIP
• Effective leadership	• The presence of knowledgeable and skilled leaders in the community made it possible to maintain operations and achieve goals after the support from the ORH ended
• Adequacy of resources	• Resources were sufficient to support the planning process • No goals have yet been unachievable due to lack of resources
• Presence of newcomers	• The involvement of team members with urban experience in planning led to comfort & competence in decision-making • Team members who were newcomers brought new ideas which contributed to creativity of the outcomes • Team members who were newcomers brought enthusiasm to the planning process
Factors in the Physical & Social Structure That Hindered Participation:	
• Physical & structural barriers (also interpersonal or psychological barriers)	• Time constraints led to absenteeism and attrition of team members • Barriers hindered members of at-risk populations from participating; reduced the diversity of participation • The issues that were addressed and goals that were chosen might have been different if at-risk groups had participated
• Ineffective leadership	• Conservative, cautious leaders attempted and may attempt to impede implementation of the CHIP goals • Controlling leaders influenced the CHIP outcomes • Controlling leaders led to dissatisfaction with CHIP for some
Factors in the Physical & Social Structure That Had a Variable Effect on Participation:	
• Small size of community	• Residents are more aware of community health needs in a small town & this provided an incentive to participate

- Small size facilitated community assessment & identification of problems
- Residents' familiarity with each other contributed to a perception of credibility & trust among team members
- Small size of community meant that impact of CHIP process was greater
- Lack of anonymity contributed to discomfort & reduced honesty & openness in team meetings
- Small size of rural organizations meant greater vulnerability for human service employees who participated in CHIP

CHAPTER IX

DISCUSSION, SUMMARY, AND IMPLICATIONS

This chapter discusses what the results of this research mean and how these results compare to related literature and the conceptual model (Figure 1). This discussion is organized around the three research aims: (a) to describe how participation has been enacted in a rural community, (b) to identify factors within the culture of rural communities that hinder or facilitate participation in community health development, and (c) to identify factors related to the physical setting and social structure of rural communities that hinder or facilitate participation in community health development. The chapter concludes with the strengths and limitations of the study and recommendations for future practice and research.

Discussion of Findings

How Participation Was Enacted

The communities shared some similarities in how participation was enacted. All contributed similar resources to support the planning process and received a similar number and range of tangible and intangible benefits. Furthermore, the communities' level of involvement in decision-making was similar. All experienced some constraint in their choice of priority health needs, but had full control over deciding how the problems should be addressed. The communities were also similar in regard to the characteristics of participants in CHIP. In each community, most of the team members were White,

middle-class women. Diversity was limited primarily to the involvement of people who represented different economic sectors, such as business owners, educators, and members of the faith community. None of the CHIP teams included people who were poor, and the representation from ethnic minority groups was very minimal.

Despite these similarities, the pattern of participation was found to vary across communities. The communities differed in commitment to the CHIP process (i.e., attendance at meetings or attrition of team members), and in team members' perception of whether the process was worthwhile. Additional differences were discovered in regard to team members' comfort with decision-making, the influence of "agendas" on decision-making, the involvement of community leaders, and the hospitals' rationale for participating in CHIP.

For the most part, it appeared that the similarities in how participation was enacted across the communities were a result of the structure of the CHIP process. The differences that were discovered, however, could be due to variation in the characteristics of the individuals who participated, in the CHIP partnership teams, or in the communities. A considerable body of research has examined the influence of individual--level characteristics on participation. Fewer studies have explored how organizational variables affect participation. Studies that examine the effect of community-level characteristics on participation are nearly non-existent (Wandersman & Florin, 2000). Perkins and associates (1990) observed that participation is unevenly distributed across communities, suggesting that many of its determining factors might reside in the social and physical environment of the community. Their study of the relationship between

neighborhood variables and participation in neighborhood associations found that a combination of catalysts in the physical environment and enablers in the social environment was positively correlated with participation. This study sought to examine whether community-level characteristics facilitated or hindered collective participation in CHIP.

The Influence of Cultural Factors on Participation

Priority given to health. While rural communities have many needs, including economic needs, health is not a low priority. However, the primary concern about health appears to be focused on health services rather than health promotion.

The discovery that health was a rather high priority in the study communities was surprising because much of the previous literature has reported that rural people prioritize health needs as secondary to work needs (Long & Weinert, 1989; Ross, 1982; Sellers et al., 1999; Weinert & Long, 1987). One explanation for the inconsistency between this study's findings and those of previous research is that the subjects of earlier studies were people who were still working, whereas in this study, the "subjects" were aging communities with many residents who were no longer working. Just as it is logical to assume that an individual's interest in health would increase with age, so too might a community's interest in health increase as its population ages.

The finding that the primary interest of the communities was health services rather than health promotion was not a surprise, however. This is consistent with the other studies which have reported that rural people take health for granted, tend to be

of this, it was assumed that rural residents would have confidence in their collective ability to solve community problems, including problems related to health. The findings from this study, however, revealed differences in the perception of the efficacy of collective action across the rural communities. Although the residents of Communities A and B appeared to be generally confident about their collective ability to improve the community, the data from Community C indicated that some residents had confidence in collective action but many did not. In addition, residents in all of the communities had doubts about their ability to improve health.

The lack of confidence in the efficacy of collective action in Community C may be related to this community's transient population. Sampson, Raudenbush, and Earls (1997) found that high mobility was negatively associated with collective efficacy, presumably because it weakened social ties. Although the respondents from Community C said that the sense of community was strong in all of the towns except Town C1, the fact that so many of the residents were newcomers might have reduced mutual trust and solidarity, and thus impacted the perception of collective efficacy. Sampson and associates also found that "concentrated disadvantage" (a cluster of poverty-related variables) was negatively associated with collective efficacy. This might explain why residents in each of the rural communities were skeptical about their ability to address health concerns. It can be argued that the small populations, limited resources, and limited "voice" or clout of rural communities may create a situation of disadvantage in terms of having an impact on the health care system and, thus, may reduce collective efficacy.

This study found that a positive perception of the efficacy of collective action to address general community problems was associated with initial and on-going commitment to participate and a willingness to address complex problems. Conversely, ambivalence about the collective ability to bring about positive change was associated with a weak commitment to participate. The findings also suggest that a community's overall confidence in collective action might mediate skepticism about health development. In Community A, where confidence in collective action appeared to be strong, the skepticism about the potential of CHIP provided a strong incentive for team members to succeed. But, in Community C, where many residents lacked confidence in collective action, the skepticism about addressing health concerns led to attrition of CHIP team members representing the non-health sectors of the community.

Previous studies have found that perception of personal ability to change one's neighborhood influenced individual-level participation (Wandersman and Giamartino, 1980). In addition, perception of the efficacy of a neighborhood association has been associated with participation at the neighborhood level (Perkins et al., 1990). This study suggests that efficacy at the community-level is also important in facilitating community participation.

Insider vs. outsider differentiation. Acceptance of newcomers differed across the communities. In Community A, many people spoke of tensions that existed between old-timers and newcomers. Furthermore, some of the respondents, who had lived in the community as long as 24 years, referred to themselves as newcomers. Weinert and Long (1987) reported similar findings in an ethnographic study of rural populations. They

found that variables such as length of residence, family history, and type of occupation were used by rural residents in determining who to accept and who to trust. They also found that people who had lived in the community for up to 20 years still expected that they would be viewed as newcomers. In contrast to this research and to the findings from Community A, the data from Community C suggested that, in this community, the concepts of insider and outsider or old-timer and newcomer had little relevance. Respondents reported that, because their population includes so many newcomers, divisions between old-timers and newcomers are not apparent.

In contrast to the expectation that rural community participation is facilitated if the leader is accepted as an insider, the findings suggest that having a leader who is known is not important to most residents and may, in fact, hinder participation. Insider status was found to have little effect on residents' willingness to participate and was beneficial mainly from the standpoint of helping the coordinator know who to invite. Several respondents reported that having a leader who was unknown had facilitated participation because it allowed CHIP to be perceived as an unbiased process, a finding that was unexpected. However, for a small number of respondents in each community, the involvement of a leader who was an outsider contributed to distrust, dissatisfaction, and a weak commitment to CHIP.

The effect of a leader's status as an insider or outsider on community participation has not been described in previous literature. However, Bracht and Tsouros (1990) reported that the social acceptability of the change agent may influence participation. It was assumed that if, for rural residents, social acceptability was linked to insider status,

then insider status would facilitate participation and outsider status would be a hindrance. The fact that this study found little support for this assumption suggests that, in these rural communities, insider status was not critical to social acceptability or that factors other than the leader's familiarity were more important in facilitating participation. One factor that may be more important than familiarity is anonymity. The respondents' comments concerning the relationship between the leader's familiarity and the perception of bias in a planning process imply that, in a small community, having a leader whose opinions are not known may be more likely to facilitate participation than having a leader who is recognized as an insider. Further research is needed to fully understand this relationship.

Sense of community and commitment to community. Rural communities have frequently been described as close-knit, where residents identify with the community and experience a sense of belonging and emotional connection (ANA, 1996; Buckwalter, Smith, & Caston, 1994; Quandt et al., 1999). Thus, it was not a surprise when the respondents in this study reported that nearly all of the towns had a strong sense of community. The data suggest, however, that the concept of a sense of community is, with few exceptions, applicable only in regard to a single rural town and that divisions or rivalries are common among towns.

No literature was found that described rural residents' willingness to work on behalf of their community but it was assumed that, if there was a strong sense of community, then the residents' commitment to community might also be strong. In contrast to this expectation, the data revealed that commitment to community varied

across the study sites. While volunteerism was reported to be quite strong in Communities B and C, many of the respondents in Community A said that the same people do everything.

Earlier studies reported that a sense of community was linked to individual participation (Chavis & Wandersman, 1990; Wandersman & Giamartino, 1980). Furthermore, Perkins and associates (1990) found that neighboring and satisfaction with the block were correlated with neighborhood-level participation. The findings from this study suggest that a sense of community is also important to community-level participation and that it facilitates initial and on-going commitment to participate, the involvement of members of the community-at-large (as opposed to community leaders or professionals), and the perception that participation is worthwhile.

The effect of commitment to community on participation was, however, less certain. Very few respondents commented on this issue and no clear relationship was noted between various levels of commitment to community and participation in CHIP except in Community C, where several people said that the large numbers of retirees on their CHIP team reflected the retirees' interest in volunteering. The phenomenon of active retirees enriching their communities through a high level of volunteerism has been reported elsewhere, although not in regard to health development per se (Rowles & Watkins, 1993).

Previous literature has also been unclear concerning the effect of a commitment to community on participation. Florin and Wandersman (1984) reported that the importance of the neighborhood block and, to a lesser extent, sense of citizen duty predicted

individual participation. However, in their study of neighborhood-level participation, Perkins and associates (1990) found that communitarianism (the importance residents place on the community and working to improve it) was not significantly related to participation.

The Influence of the Physical Setting and Social Structure on Participation

Physical and structural barriers. The conceptual model for this research posited that physical and structural factors serve as barriers to rural community participation in a health development initiative. The findings extended the conceptual model by showing that psychological or interpersonal factors, as well as physical and structural factors, hindered participation. Respondents from each study site described several barriers that impeded the involvement of certain sectors including the low-income population, ethnic minority populations, and youth. The barriers cited most often included time constraints, distance, lack of public transportation, not being invited, and not feeling comfortable at the CHIP meetings.

The negative effect of barriers on participation has been described in previous literature. Prestby and associates (1990) found that the perception of barriers such as time constraints, lack of child care, and not feeling welcome at meetings could inhibit individual participation. In addition, Cohen and Uphoff (1980) reported that physical barriers such as poor roads have the potential to impede participation in rural community development efforts and that political and social factors may serve as barriers to participation for groups that are poor or in other ways marginalized.

Civic organization and experience with social planning. The literature on community competence suggests that one important precondition of competence is the involvement of residents in community organizations, such as civic clubs or church groups (Cottrell, 1976). Community organizations are viewed as important because they enable residents to have regular contact and to develop interpersonal connections (Goodman et al., 1998).

The rural communities that participated in this study were found to have many voluntary organizations. For the most part, these were described as active and popular although, in Community A, it was reported that the membership in these organizations was small. The data, however, revealed that the presence of voluntary organizations had little effect on participation. Very few of the respondents were able to describe a relationship between voluntary organizations and participation in CHIP, except for stating that many of the CHIP team members were also active in other organizations. One explanation for the limited association between voluntary organizations and participation might be that, because rural communities are small, the residents have many opportunities to interact. Thus, in a rural area, voluntary organizations may not be as important to the development of interpersonal connections as they would be in an urban setting.

One finding that was discovered across study sites, albeit on a limited basis, was that the participation of CHIP team members in other community organizations had enabled them to acquire skills that were useful in the health development work of CHIP. This finding is supported by previous literature on empowerment, which suggests that

people can develop personal efficacy and competence by participating in an empowering organization, where they work with others on mutually defined goals (Israel et al., 1994; Schultz et al., 1995).

The case study data revealed that the communities had different levels of experience with social and health planning and that, while a positive history of planning facilitated participation in CHIP, a negative history of planning had little effect on participation. Many respondents in Community C said that this community's experience and success in planning enhanced decision-making and contributed to residents' willingness to participate in CHIP. On the other hand, the majority of respondents in Communities A and B reported that their community's limited experience or success in planning had no effect on participation in CHIP, a finding that was unexpected. One possible explanation for this is that the structure of CHIP and the assistance that was provided by the ORH gave the community members confidence in the process despite the negative history of planning.

The only hindrance attributed to limited experience in planning was reported by a small number of respondents in Community A. They observed that their community's lack of experience in planning and history of program failures contributed to skepticism concerning the potential of CHIP. The finding has support in previous literature. Cohen and Uphoff (1980) wrote that a negative history with planning could cause residents to distrust new community development efforts.

Leadership. The communities that participated in this study had many leaders who were progressive and skilled in working with people and in leading change, but also some leaders who lacked management skills and were resistant to change. The presence of many competent leaders was not anticipated. Previous literature in community development has described rural leadership as largely unskilled and conservative or cautious in regard to change (Veblen-Mortenson et al., 1999; Voth & Jackson, 1981).

Although the focus of this study was on community-level characteristics, the findings suggest that organizational-level leadership has a greater influence on participation than community-level leadership, at least during the planning phase. The majority of respondents, when asked if the strengths or weaknesses of the community's leadership had an effect on participation in CHIP, spoke of the importance of having strong leaders on the CHIP partnership team. The participation of people with strong leadership skills was linked to a satisfying group process, effective decision-making, the establishment of realistic goals, and enhanced team member commitment. On the other hand, the absence of leaders on the CHIP team was associated with weak decision-making, an unsatisfactory group process, attrition of team members, and a reduced potential to secure resources needed to achieve the goals. These findings are consistent with those of previous studies which have reported that leader competence at the organizational-level is associated with effectiveness of coalitions during the stages of formation and early maintenance (Butterfoss et al., 1996; Kumpfer, Turner, Hopkins, & Librett, 1993).

Leadership at the community-level may be more important during the implementation phase of a health development effort than during the planning phase. The paucity of comments received from respondents concerning community-level leadership might be related to the fact that this study focused on what had helped or hindered participation during the planning phase. The few statements that did pertain to community-level leadership suggest that the competence and boldness of community leaders, or lack thereof, has an effect on implementation. In Community B, one respondent reported that the presence of skilled and knowledgeable community leaders made it possible for the CHIP team to maintain operations and implement several complex projects after the planning phase ended and the ORH was no longer involved. On the other hand, a small number of respondents in each study site said that the presence of conservative community leaders had the potential to impede implementation of the CHIP goals.

Support for the importance of organization-level leadership to coalition effectiveness during the implementation phase was found in a study by Kegler and associates (1998). The findings from this study suggest that leadership at the community-level is also important to implementation. Further studies are needed, however, to confirm this relationship.

Resources. Previous literature has reported that the shortage of resources in rural communities has a negative effect on community development (Voth & Jackson, 1981; Wilkinson, 1986). However, this study found that resources in all categories (i.e., physical, technical, professional, and financial) were adequate during the CHIP planning

phase. One likely explanation for the inconsistency between these findings and earlier literature is that the study communities were required to assure that resources were available before they were permitted to participate in CHIP and, in addition, they received considerable financial, technical, and professional support from the ORH.

Whether the communities' potential to implement their health improvement goals will be hindered by a shortage of resources is yet uncertain. However, early indications suggest that limited resources will not prove to be a hindrance in at least two of the study sites.

Additional Findings

Small size. The small size of the study communities both facilitated and hindered community participation in CHIP. Small size was identified as an advantage in that the residents were familiar with each other and with the community's needs. This familiarity motivated them to participate, enhanced trust among the CHIP team members, and facilitated community assessment. However, small size also emerged as a disadvantage in Community A, the smallest of the three study communities, because of the lack of anonymity it afforded. Lack of anonymity contributed to a reluctance to be confrontational, a reduction in honesty and openness during team deliberations, and to a heightened sense of vulnerability among some team members.

Previous studies have reported similar findings. Goodman and associates (1998) noted that communities whose residents are closely connected (although not necessarily because of community size) were more willing to mobilize to address community concerns. Also, Wilkinson (1986) reported that small size typically means fewer

problems with communication, coordination, and integration, which is advantageous in community development. On the other hand, Veblen-Mortenson and associates (1999), in their work with a rural alcohol abuse prevention coalition, found that, because residents knew each other well, the coalition members were extremely cautious about using conflict-generating strategies to bring about change and, instead, preferred to use strategies that were consensual. The propensity of rural communities to depend upon consensus and to avoid conflict was also reported by Voth and Jackson (1981), who noted that this weakens decision-making.

The presence of newcomers. The findings from this study suggest that the presence of newcomers who have come from urban areas facilitates rural community participation in a health development initiative. The positive effect of newcomers, including retirees, on participation has not previously been reported. However, an earlier study of the impact of elderly migration on small communities lends support to this observation. Rowles and Watkins (1993) described how the environment of a rural town was altered by an influx of urban retirees. As the number of retirees increased, economic, environmental, infrastructural, social, and political changes occurred. Among the changes they identified that help to explain the findings in this study was that the community became increasingly cosmopolitan as evidenced by an aesthetic downtown area with boutiques and restaurants, the presence of national newspapers and professional publications, a community activity center, a symphony, and a summer playhouse. If such changes in the physical and social environment occur as a result of migration from urban

areas, it follows that the impact on community health development may be equally dramatic.

The perception of the hospital. The relationship between a community's perception of its hospital and participation in a health development initiative has also not been reported previously but may be related to the importance of social acceptability of the change agent, which Bracht and Tsouros (1990) mention. The literature on community participation has described the importance of having the impetus come from a local group or organization, as opposed to an organization outside the community, for participation to be empowering (Cohen & Uphoff, 1980; Fawcett et al., 1995). The findings from this study suggest that it is not enough for the organization simply to be local, but that participation is also influenced by the community's respect for the sponsoring organization.

Recent funding reductions. Although not a community characteristic per se, the impact of a statewide economic crisis on one community's participation in CHIP is important to mention. The CHIP initiative in Community C began during a time when county human services were experiencing severe reductions in state funding. (See Community C case description.) The effect of this timing on participation in CHIP was significant. A large number of respondents in this community reported that the budgetary crisis had a negative effect on group process (i.e., conflict during meetings), the willingness of certain residents to participate, the perception of CHIP as being worthwhile, and on the CHIP outcomes.

The CHIP initiative in Community A began just three months after Community C effort started, yet the reductions in state funding to human service programs were not mentioned in this community. The reason for this difference is unclear.

Strengths and Limitations of the Study

A major strength of this study is that it examined community-level influences on participation. Although much research has sought to uncover the factors that hinder or facilitate participation, nearly all of this work has been focused on characteristics of individuals or organizations. Very few studies have explored how community characteristics affect participation (Perkins et al., 1990). Also, no previous studies have examined how rurality affects participation. Thus, the findings from this study are an important contribution to the knowledge base.

Another strength of this study is the multiple-case study design. The individual case descriptions provide insight into rural community characteristics and how these influence participation. The cross-case comparisons help to explain the variances observed in the pattern of community participation.

A third strength of this study is the naturalistic nature of the research. Time spent in the communities and with study participants, who graciously shared their insights with the researcher, contributed information that would have otherwise been unavailable and, thus, strengthened the findings.

A fourth strength is the use of multiple sources of data. Although interviews were the primary source of data, community observation and document review were useful in corroborating the interview findings.

A fifth strength of this study is that the researcher, because of her experience in living and working in rural communities, had some familiarity with the phenomenon and the setting that were investigated. According to Miles and Huberman (1994), this is one mark of a good qualitative "researcher-as-instrument."

The study is not without limitations, however. One major limitation is that this research only examined rural communities. Without a comparison to urban communities, it is not possible to know whether the characteristics that were identified or the manner in which they impacted participation is unique to a rural setting.

Another limitation, particularly from a qualitative perspective, is that the study had only a single investigator who both collected and analyzed the data. Although the interview summaries, coding scheme, and case descriptions were reviewed by members of the investigator's doctoral committee, the lack of co-investigators heightens the potential for researcher bias.

A third limitation is the small number and limited diversity of cases. Only three communities were included in this study and they had many characteristics in common. All were predominately Caucasian, all had a similar percentage of the population living below poverty, and all had a hospital. Thus, the findings are less robust than would be true of studies employing a larger number and wider variety of cases.

A fourth limitation concerned the timing of the study. Because the data were collected several months after the communities had begun the CHIP process, it is possible that the respondents might have been unable to recall all of the factors that impeded or facilitated their community's participation. This is particularly a concern in regard to

Community B, since that community began its CHIP process two years prior to the data collection. Furthermore, the respondents' recollection of barriers to participation might have been diminished because of the fact that the communities had made progress in planning and had experienced some success.

Another limitation related to timing is that the data were collected on only one occasion. The fact that the investigator spent several days in each community is a strength. However, the lack of repeat visits means that it is impossible to know whether the community characteristics that were found to have little effect on participation at the time of the study would emerge as a hindrance or an asset at a later point.

Whether the respondents adequately represented their communities is also a concern. Although an attempt was made to involve participants from a variety of community sectors, it is recognized that the individuals who were involved in the CHIP process were likely to differ in significant ways from members of the community who did not participate in CHIP. Thus, the descriptions that emerged from this investigation may reflect a biased view of the communities.

Finally, the structured nature of the CHIP process undoubtedly had an effect on the findings. While, in some respects, the structure was helpful because it assured that all of the communities were involved in a process of similar magnitude, it is also likely that the structure of the process and the resources that were provided to the communities from the ORH mediated or masked the effect of community characteristics on participation. Because of this limitation and the others that have been described, the results of this research should be interpreted with caution.

Implications for Practice

The findings from this study shed light on our understanding of rural communities and the support they may need to succeed in a health development effort. The findings are encouraging in that several community characteristics that were expected to hinder health development efforts in rural communities were either not present or did not pose a hindrance. It was discovered, for example, that rural communities are able to access resources and have enough competent leadership to be successful in health development. Furthermore, it was found that limited experience or success in previous community planning is not necessarily a hindrance, nor is the involvement of a leader who is perceived as an outsider.

It is recommended that careful thought be given to selecting the leader and members of the health development coalition. This research suggests that rural communities have many residents with leadership skills, such as skills in group process and decision-making, and that their involvement in the health development team contributes greatly to success in planning. However, the findings also suggest that the involvement of leaders who are widely known in the community can hinder a health development effort. The advantages and disadvantages of involving community leaders who are known should be weighed and possibly discussed with members of the community before the team members are chosen. It may be useful to involve some people who are known leaders as well as some who are relatively unknown, perhaps new to the community. The involvement of a combination of known and unknown leaders could be especially beneficial if they are assigned different roles. For example, it may be

advantageous to have a leader or team member who is considered an outsider gather feedback from other participants on the issues or proposals being discussed and present the findings to the group so that team members have an opportunity for anonymous input. In some communities, it may also be advantageous to have an unknown leader issue the invitations to participate in the health development effort. On the other hand, involving a leader who is known and respected in leading the discussion of community problems may reduce defensiveness or resentment among team members.

Another aspect to consider in selecting team members is the involvement of newcomers. The results of this study suggest that the participation of people who are new to the community in the health development team is beneficial because they contribute ideas and enthusiasm, which strengthens the planning process. The combination of newcomers and old-timers on the planning team did not result in conflict, even in a community where tension between these groups was reported, and, in fact, appeared to helpful in reducing the divisions.

It is also advisable to consider what community organization is best suited to sponsor the health development initiative. The findings suggest that, in a small community, an organization's reputation can be widespread and can have a significant effect on participation. The findings particularly showed that linking the health development effort to an organization that was held in esteem by residents had a positive influence on participation.

Because the structure of the CHIP process appeared to compensate for some "weaknesses" in the rural communities, it is recommended that a similar degree of

structure be provided to other rural towns that are engaging in a health development initiative. The structured assistance that was offered to assist the communities in decision-making was likely the reason that limited experience and success with previous planning efforts did not hinder participation in CHIP. In addition, the requirement that the communities secure resources before engaging in the planning effort meant that the health development process was not hindered by lack of resources. The fact that the ORH contributed funds to pay for a portion of the coordinator's salary and project start-up costs likely provided an incentive to rural communities to participate in CHIP, but appeared to not be critical since the communities did not have difficulty accessing additional resources.

In order to encourage the participation of residents from outside the health sector, it is important to raise awareness of health concerns while, at the same time, instill confidence that community efforts can make a difference. The results of this study suggest that, when the community-at-large is aware of and concerned about health care problems in the community, residents from diverse sectors are motivated to participate. Conversely, when the community-at-large is unaware or unconcerned, the health development team will consist mainly of health providers. The findings also suggest that rural residents are skeptical about their ability to improve community health but that a high level of confidence in achieving general community improvements can mediate the skepticism. In order to assess the community's level of awareness and concern, as well as their perception of the efficacy of collective actions pertaining to health, instruments used for assessing community readiness may be helpful. One such instrument was

developed by the Tri-Ethnic Center for Prevention Research at Colorado State University (Plested et al., 1999). For communities with a low level of awareness or confidence, it may be useful to provide community-wide education concerning local health problems and their impact on the community, offer ideas of what other rural communities have done to address their health needs, and assist the team members to recognize the successes they have had in addressing other community concerns.

Broad-based participation can also be encouraged through efforts to reduce community barriers. It is recommended that the leaders of the health development initiative make concrete assistance available (such as childcare, transportation, or language interpreters). In addition, the leaders can reduce psychological or interpersonal barriers by taking steps to make all participants feel welcome. These recommendations are consistent with the findings from a study by Prestby and associates (1990), who reported that a leader's incentive management efforts were linked to higher member benefits and lower costs, and thus had a direct effect on individual participation.

Recommendations for Policy

Although the CHIP program supported the right of citizens to be involved in decisions that affect their lives, it was not fully consistent with the principles of community participation. Diversity of the CHIP participants was primarily interpreted as a cross-section of the economic sectors of the community, and little emphasis was placed on the active involvement of citizens representing groups that have traditionally been disenfranchised. The CHIP team members were encouraged to seek input from people

who are receiving health and social services, however the degree to which this occurred was neither mandated nor monitored.

Given the significance of full community participation in efforts to address health disparities, it is recommended that broad-based community involvement be a requirement for communities participating in CHIP or in other similar health development initiatives. To ensure broad-based community involvement, it is recommended that:

- coalition partners and community leaders be required to participate in training on the meaning and value of community participation. This training should emphasize the importance of assessing and utilizing the assets or strengths of various sectors, and should describe how to establish and maintain equitable relationships among community partners.
- funding for the health development initiative be contingent upon evidence of the involvement of participants who represent the ethnic and class diversity of the community.
- the evaluation of the health development initiative include an assessment of the relationship between community partners, and the impact of the resulting projects on reducing health disparities.

Recommendations for Future Research

This study identified several community characteristics that have an effect on participation in a health development initiative. However, because the study did not compare rural communities to urban communities, it is impossible to know whether the

characteristics that were identified are unique to a rural setting. It is advised, therefore, that future studies involving both urban and rural communities be conducted.

Some of the characteristics that were examined in this study varied across the communities and appeared to be linked to community size and isolation. For example, the perception of efficacy concerning community action seemed to be stronger in the smallest community and weakest in the community that was largest and least isolated. At the same time, the smallest community had the least experience and success in planning while the largest community had considerable planning experience and success. This observation suggests that it may be useful to conduct additional research using a greater number of communities that represent a range of rurality. Doing this might reveal patterns that were not evident in this study due to the small size of the sample. Similarly, replicating the study in rural communities that differ in terms of ethnic composition, socioeconomic status, and the like would be useful in determining whether demographic variations have a differing effect on participation.

It is also recommended that future studies be conducted to examine the impact of community characteristics throughout the stages of a health development initiative, from initial mobilization through implementation and institutionalization. It is conceivable that factors in the environment of a community that have no effect on participation at one stage may emerge as being a hindrance or an asset during another stage. Thus, collecting data over time may be informative.

Finally, it is recommended that this study be replicated in communities that are engaging in health development efforts with little or no outside support. This would allow the effect of community characteristics on participation to be more evident.

A Challenge to Nurses

Although the purpose of this study was not to examine the role that nurses played in CHIP, it was noted that few nurses participated in the CHIP teams and none appeared to advocate for broad-based involvement of residents in the CHIP decision-making process. This is unfortunate, since it likely reflects a lack of interest in or understanding of community-based practice among the nurses in these communities.

The nursing profession has a long and proud history of helping communities to improve their health, yet for many years, nurses have focused almost exclusively on the health care needs of individuals and families. In light of the vast literature supporting the importance of community-based approaches in addressing health disparities, it is time for nurses to renew their commitment to community health. If nursing is to have an impact in reducing health disparities, it is essential that we make every effort to become involved in deliberations, such as CHIP, that focus upon models and approaches for improving public health. Further, we must also challenge policymakers, as well as the organizations that we work for, to promote the principles of community participation. And, finally, we must ensure that future nurses are prepared for community-based work by providing experiential learning opportunities to baccalaureate and graduate students and by demonstrating, through example, the role of a nurse leader in community-based practice.

Summary

The findings from this study provide evidence that factors in the culture and the physical and social structure of rural communities have an effect on community participation in a health development initiative. Support is found for most of the factors in the conceptual model, and the data suggest how these factors impact participation. Additional community-level factors that influence participation are also revealed. Furthermore, the findings provide valuable insight into the characteristics of rural communities. Due to the nature of this research, it was not possible to demonstrate that rurality per se has an effect on participation. Further studies are needed to clarify our understanding of rural communities and the impact of community characteristics on participation.

REFERENCE LIST

American Nurses Association. (1996). *Rural/frontier nursing: The challenge to grow.* Washington, DC: American Nurses Publishing.

Annett, H., & Nickson, P.J. (1991). Community involvement in health: Why is it necessary? *Tropical Doctor, 21*, 3-5.

Antonovsky, A. (1979). *Health, stress, and coping.* San Francisco: Jossey-Bass.

Antonovsky, A. (1988). *Unraveling the mystery of health: How people manage stress and stay well.* San Francisco: Jossey Bass.

Arcury, T., Austin, C.K., Quandt, S.A., & Saavedra, R. (1999). Enhancing community participation in intervention research: Farmworkers and agricultural chemicals in North Carolina. *Health Education & Behavior, 26*(4), 563-578.

Arcury, T.A., Quandt, S.A., & Bell, R.A. (2001). Staying healthy: The salience and meaning of health maintenance behaviors among rural older adults in North Carolina. *Social Science & Medicine, 53*(11), 1541-1556.

Arnstein, S. (1971). Eight rungs on the ladder of citizen participation. In E.S. Cahn & B.A. Passett (Eds.), *Citizen participation: Effecting community change* (pp. 69-91). New York: Praeger.

Barnes, D., Eribes, C., Juarbe, T., Nelson, M., Proctor, S., Sawyer, L.M., Shaul, M., & Meleis, A.I. (1995). Primary health care and primary care: A confusion of philosophies. *Nursing Outlook, 43*(1), 7-16.

Baum, F.E., Bush, R.A., Modra, C.C., Murray, C.J., Cox, E.M., Alexander, K.M., & Potter, R.C. (2000). Epidemiology of participation: an Australian community study. *Journal of Epidemiology in Community Health, 54*, 414-423.

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Bracht, N., & Tsouros, A. (1990). Principles and strategies of effective community participation. *Health Promotion International, 5*(3), 199-208.

Buckwalter, K. C., Smith, M., & Caston, C. (1994). Mental and social health of the rural elderly. In R. T. Coward, C. N. Bull, G. Kukulka & J. M. Galliher (Eds.), *Health Services for Rural Elders* (pp. 203-232). New York: Springer.

Butterfoss, F.D., Goodman, R.M., & Wandersman, A. (1996). Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation, and planning. *Health Education Quarterly, 23*(1), 65-79.

CDC/ATSDR Committee on Community Engagement. (1997). *Principles of community engagement.* Atlanta, GA: Centers for Disease Control and Prevention.

Chavis, D.M., & Wandersman, A. (1990). Sense of community in the urban environment: A catalyst for participation and community development. *American Journal of Community Psychology, 18*(1), 55-81.

Chinman, M.J., Anderson, C.M., Imm, P.S., Wandersman, A., & Goodman, R.M. (1996). The perceptions of costs and benefits of high active versus low active groups in community coalitions at different stages of coalition development. *Journal of Community Psychology, 24*(3), 263-274.

Cohen, J.M., & Uphoff, N.T. (1980). Participation's place in rural development: Seeking clarity through specification. *World Development, 8*, 213-235.

Cottrell, L.S. (1976). The competent community. In B.H. Kaplan, R.N. Wilson, & A.H. Leighton (Eds.), *Further exploration in social psychiatry* (pp. 195-209). New York: Basic Books.

Counts, M., & Boyle, J. (1987). Nursing, health, and policy within a community context. *Advances in Nursing Science, 9*(3), 12-23.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Denzin, N.K. (1978). *Sociological methods: A source book* (2nd ed.). New York: McGraw-Hill.

Denzin, N.K., & Lincoln, Y.S. (Eds.). (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Eberhardt, M.S., Ingram, D.D., Makuc, D.M., Pamuk, E.R., Freid, V.M., Harper, S.B., Schoenborn, C.A., & Xia, H. (2001). *Urban and rural health chartbook.* Hyattsville, MD: National Center for Health Statistics.

Fawcett, S. B., Paine-Andrews, A., Francisco, V. T., Schultz, J. A., Richter, K. P., Lewis, R. K., et al. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology, 23* (5), 677-697.

Florin, P., Jones, E., & Wandersman, A. (1986). Black participation in voluntary associations. *Journal of Voluntary Action Research, 15*, 65-86.

Florin, P., & Wandersman, A. (1984). Cognitive social learning and participation in community development. *American Journal of Community Psychology, 12*(6), 689-708.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Goeppinger, J. (1993). Health promotion for rural populations: Partnership interventions. *Family & Community Health, 16*(1), 1-10.

Goodman, R.M., Speers, M.A., McLeroy, K.R., Fawcett, S., Kegler, M.C., Parker, E., Smith, S.R., Sterling, T.D., & Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education & Behavior, 25*(3), 258-278.

Heaney, C.A., & Israel, B.A. (1997). Social networks and social support. In K. Glantz, F.M. Lewis, & B.K. Rimer (Eds.), *Health behavior and health education* (pp. 179-205). San Francisco: Jossey-Bass.

Hornberger, C.A., & Cobb, A.K. (1998). A rural vision of a healthy community. *Public Health Nursing, 15*(5), 363-369.

Israel, B.A., Checkoway, B., Schulz, A., & Zimmerman, M. (1994). Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly, 21*(2), 149-170.

Jewkes, R., & Murcott, A. (1998). Community representatives: Representing the "community"? *Social Science Medicine, 46*(7), 843-858.

Kauffman, S., & Poulin, J. (1994). Citizen participation in prevention activities: A path model. *Journal of Community Psychology, 22*, 359-374.

Kegler, M.C., Steckler, A., McLeroy, K.R., & Malek, S.H. (1998). Factors that contribute to effective community health promotion coalitions: A study of 10 Project

ASSIST coalitions in North Carolina. *Health Education & Behavior, 25*(3), 338-353.

Kreuter, M.W., Lezin, N.A., & Young, L.A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice, 1*(1), 49-63.

Krueger, R.A. (1998). *Developing questions for focus groups*. Thousand Oaks, CA: Sage.

Kumpfer, K.L., Turner, C., Hopkins, R., & Librett, J. (1993). Leadership and team effectiveness in community coalitions for the prevention of alcohol and other drug abuse. *Health Education Research, 8*(3), 359-374.

Lasker, R.D., Weiss, E.S., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Milbank Quarterly, 79*(2), 179-205.

Lassiter, P.G. (1992). A community development perspective for rural nursing. *Family and Community Health, 14*(4), 29-39.

Lee, H.J. (1993). Health perceptions of middle, "new middle", and older rural adults. *Family & Community Health, 16*(1), 19-27.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Long, K.A. (1993). The concept of health: Rural perspectives. *Nursing Clinics of North America, 28*(1), 123-130.

Long, K.A., & Weinert, C. (1989). Rural nursing: Developing the theory base. *Scholarly Inquiry for Nursing Practice, 3*(2), 113-127.

Magilvy, J.K., Brown, N.J., & Moritz, P. (1999). Community-focused interventions and outcomes strategies. In A. S. Hinshaw, S. L. Feetham, & J. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 125-143). Thousand Oaks, CA: Sage.

McClure, L., & DePiano, L. (1983). School advisory council participation and effectiveness. *American Journal of Community Psychology, 11*, 687-704.

McGinnis, P., & Przybilla, J. (1999). *Community health improvement partnership: A rural community health development process*. Unpublished manuscript.

McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly, 15*(4), 351-377.

Meleis, A.I. (1992). Community participation and involvement: Theoretical and empirical issues. *Health Services Management Research, 5*(1), 5-16.

Mertens, D.M. (1998). *Research methods in education and psychology*. Thousand Oaks, CA: Sage.

Miles, M.B., & Huberman, A.M. (1994).*Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Minkler, M., & Wallerstein, N. (1997). Improving health through community organization and community building: A health education perspective. In M.

Minkler (Ed.), *Community organizing and community building for health* (pp. 30-52). New Brunswich, NJ: Rutgers University Press.

Mischel, W. (1973). Toward a cognitive social learning reconceptualization of personality. *Psychological Review, 80*, 252-283.

Morgan, D.L. (1997). *Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

National Institute of Nursing Research (NINR). (1995). *Community-based health care: Nursing strategies* (NINR Pub. No. 95-3917). Bethesda, MD: U.S. Department of Health and Human Services.

O'Connor, D., & Gates, C.T. (2000). Toward a healthy democracy. *Public Health Reports, 115*(2-3), 157-160.

Office of Rural Health. (2003). *Demographic, socioeconomic, and health status report.* Portland: Oregon Health and Science University.

Patton, M.Q. (2002).*Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Perkins, D.D., Florin, P., Rich, R., Wandersman, A., & Chavis, D.M. (1990). Participation and the social and physical environment of residential blocks: Crime and community context. *American Journal of Community Psychology, 18*(1), 83-115.

Piven, F.F. (1968). Participation of residents in neighborhood community action programs. In H.Spiegel (Ed.), *Citizen participation in urban development* (pp. 113-127). Washington, D.C.: NTL Institute for Applied Behavioral Science.

Plested, B., Smitham, D., Jumper-Thurman, P., Oetting, E., & Edwards, R. (1999). Readiness for drug use prevention in rural minority communities. *Substance Use and Misuse, 34*, 521-544.

Portland State University (PSU), Portland, Population Research Center. (2002). *Oregon Population Report.* Retrieved February 19, 2003, from http://www.upa.pdx.edu/CPRC/

Prestby, J.E., & Wandersman, A. (1985). An empirical exploration of framework of organizational viability: Maintaining block organizations. *The Journal of Applied Behavioral Science, 21*, 287-305.

Prestby, J.E., Wandersman, A., Florin, P., Rich, R., & Chavis, D.M. (1990). Benefits, costs, incentive management and participation in voluntary organizations: A means to understanding and promoting empowerment. *American Journal of Community Psychology, 18*(1), 117-149.

Quandt, S.A., McDonald, J., Bell, R.A., & Arcury, T. (1999). Aging research in multi-ethnic rural communities: Gaining entree through community involvement. *Journal of Cross-Cultural Gerontology, 14*, 113-130.

Ricketts, T.C., Johnson-Webb, K.D., & Randolph, R.K. (1999). Population and places in rural America. In T.C. Ricketts (Ed.), *Rural health in the United States* (pp. 7-24). New York: Oxford University Press.

Rifkin, S.B. (1986). Lessons from community participation in health programmes. *Health Policy and Planning, 1*(3), 240-249.

Rifkin, S.B. (1990). *Community participation in maternal and child health/family planning programmes*. Geneva: World Health Organization.

Rifkin, S.B., Muller, F., & Bichmann, W. (1988). Primary health care: On measuring participation. *Social Science Medicine, 26*(9), 931-940.

Robertson, A., & Minkler, M. (1994). New health promotion movement: A critical examination. *Health Education Quarterly, 21*(3), 295-312.

Rosenblatt, R.A., & Hart, L.G. (1999). Physicians and rural America. In T.C. Ricketts (Ed.), *Rural health in the United States* (pp. 38-51). New York: Oxford University Press.

Ross, H. (1982). Women and Wellness: Defining, Attaining, and Maintaining Health in Eastern Canada. *Dissertation Abstracts International, 42*, DEO 82-12624.

Rowles, G. D. & Watkins, J. F. (1993). Elderly migration and development in small communities. *Growth and Change*, 24, 509-538.

Rural Health Research Center (2002). *Rural-Urban Commuting Area Codes (RUCAs)*. Retrieved February 3, 2003, from http:/www.fammed.washington.edu/ wwamirhrc/ rucas/rucas.html

Rural Information Center Health Service (RICHS). *Rural health statistics*. Retrieved November 2, 2001, from http:/www.nal.usda.gov/ric/richs/ stats.htm

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*, 918-924.

Sawyer, L.M. (1995). Community Participation: Lip Service? *Nursing Outlook, 43*, 17-22.

Schoenberg, N.E., Campbell, K.A., Garrity, J.E., Snider, L.B., & Main, K. (2001). The Kentucky Homeplace Project: Family health care advisers in underserved rural communities. *Journal of Rural Health, 17*(3), 179-186.

Schulz, A.J., Israel, B.A., Zimmerman, M., & Checkoway, B. (1995). Empowerment as a multi-level construct: Perceived control at the individual, organizational and community level. *Health Education Research, 10*(3), 309-327.

Schur, C.L., & Franco, S.J. (1999). Access to health care. In T.C. Ricketts (Ed.), *Rural health in the United States* (pp. 25-37). New York: Oxford University Press.

Schwab, M., & Syme, S.L. (1997). On paradigms, community participation, and the future of public health. *American Journal of Public Health, 87*(12), 2049-2051.

Sellers, S.C., Poduska, M.D., Propp, L.H., & White, S.I. (1999). The health care meanings, values, and practices of Anglo-American males in the rural Midwest. *Journal of Transcultural Nursing, 10*(4), 320-330.

Shreffler, M.J. (1999). Culturally sensitive research methods of surveying rural/frontier residents. *Western Journal of Nursing Research, 21*(3), 426-435.

Smith, J.A. (1983). *The idea of health: Implications for the nursing professional.* New York: Teachers College Press.

Smith, S.L., Blake, K., Olson, C.R., & Tessaro, I. (2002). Community entry in conducting rural focus groups: Process, legitimacy, and lessons learned. *Journal of Rural Health, 18*(1), 118-123.

Speer, P.W., Jackson, C.B., & Peterson, N.A. (2001). The relationship between social cohesion and empowerment: Support and new implications for theory. *Health Education & Behavior, 28*(6), 716-732.

Spencer, G.A., & Morgan, L.L. (2001). Rural populations. In K. Lundy & S. Janes (Eds.), *Community health nursing: Caring for the public's health* (pp. 618-635). Boston: Jones and Bartlett.

Stake, R.E. (1995). *The art of case study research.* Thousand Oaks, CA: Sage.

Stein, H.F. (1982). The annual cycle and the cultural nexus of health care behavior among Oklahoma wheat farming families. *Culture, Medicine and Psychiatry, 6*, 81-99.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Summer, L. (1991). *Limited access: Health care for the rural poor.* Washington, D.C.: Center on Budget and Policy Priorities.

Thompson, B., & Kinne, S. (1999). Social change theory: Applications to community health. In N. Bracht (Ed.), *Health promotion at the community level* (pp. 29-58). Thousand Oaks, CA: Sage.

Thorson, J., & Powell, F. (1992). Rural and urban elderly construe health differently. *The Journal of Psychology, 126*, 251-260.

U.S. Census Bureau. (n.d.). *Profile of General Demographic Characteristics: 2000.* Retrieved January 31, 2003, from http://www.factfinder.census.gov

U.S. Department of Agriculture, Economic Research Service (USDA). (1997). *Rural conditions and trends* 8(2). Washington, DC: Author.

U.S. Department of Agriculture, Economic Research Service (USDA). (1999). *Rural conditions and trends* 9(2). Washington, D.C.: Author.

U.S. Department of Agriculture, Economic Research Service (USDA). *Measuring rurality: Rural-urban commuting area codes*. Retrieved September 11, 2002, from http:/www.ers.usda.gov/Briefing/Rural/Data/desc.ht

Veblen-Mortenson, S., Rissel, C., Perry, C., Forster, J., Wolfson, M., & Finnegan, J. (1999). Lessons learned from Project Northland: Community organization in rural communities. In N. Bracht (Ed.), *Health promotion at the community level* (pp. 105-117). Thousand Oaks, CA: Sage.

Voth, D.E., & Jackson, V.N. (1981). *Evaluating citizen participation: Rural and urban community development* (WPS-80-01). Washington, D.C.: Center for Responsive Governance.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion, 6*(3), 197-205.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly, 15*(4), 379-394.

Wandersman, A., & Florin, P. (2000). Citizen participation and community organizations. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 247-272). New York: Kluwer Academic/Plenum Publishers.

Wandersman, A., Florin, P., Friedmann, R., & Meier, R. (1987). Who participates, who does not, and why? An analysis of voluntary neighborhood organizations in the United States and Israel. *Sociological Forum, 2*, 534-555.

Wandersman, A., & Giamartino, G.A. (1980). Community and individual difference characteristics as influences on initial participation. *American Journal of Community Psychology, I*, 217-229.

Wandersman, A., Jakubs, J.F., & Giamartino, G.A. (1981). Participation in block organizations. *Community Action, 1*(1), 40-47.

Weinert, C., & Burman, M.E. (1994). Rural health and health-seeking behaviors. *Annual Review of Nursing Research, 12*, 65-92.

Weinert, C., & Burman, M.E. (1996). Nursing of rural elders: Myth and reality. In E.A. Swanson & T. Tripp-Reimer (Eds.), *Advances in gerontological nursing* (pp. 57-79). New York: Springer.

Weinert, C., & Long, K.A. (1987). Understanding the health care needs of rural families. *Family Relations, 36*, 450-455.

Weinert, C., & Long, K.A. (1990). Rural families and health care: Refining the knowledge base. In M. Sussman & D. Unger (Eds.), *Families in community settings* (pp. 57-75). New York: Haworth.

Wilkinson, K.P. (1986). In search of the community in the changing countryside. *Rural Sociology, 51* (1), 1-17.

Woelk, G.B. (1992). Cultural and structural influences in the creation of and participation in community health programmes. *Social Science Medicine, 35*(4), 419-424.

World Health Organization (WHO). (1978). *Primary health care, Report of the International Conference on Primary Health Care, Alma-Ata, USSR.* Geneva: World Health Organization.

World Health Organization (WHO). (1995). *Renewing the Health for All Strategy.* Geneva: World Health Organization.

World Health Organization (WHO) Study Group. (1991). *Community involvement in health development: Challenging health services* (WHO Technical Report Series 809). Geneva: World Health Organization.

Yin, R.K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.

Zimmerman, M.A. (1990). Toward a theory of learned hopefulness: A structural model analysis of participation and empowerment. *Journal of Research in Personality, 24*, 71-86.

Zimmerman, M. (2000). Empowerment theory: Psychological, organizational, and community levels of analysis. In J. Rappaport & E. Seidman (Eds.), *Handbook of*

community psychology (pp. 43-63). New York: Kluwer Academic/Plenum Publishers.

APPENDIX A

INTRODUCTORY LETTER FOR CHIP COORDINATORS

Date

Name
Address

Dear (*CHIP coordinator name*):

I am writing to let you know about a research study that I am conducting in Oregon and to request your support and participation. I believe that Paul McGinnis, of the Office of Rural Health, told you that I would be contacting you concerning this study.

I am a graduate student at the Oregon Health & Science University School of Nursing. The study that I am conducting is part of the research required for my doctoral degree. The purpose of this study is to explore how rurality affects the ability of a community to participate in a health development process. More specifically, I am interested in learning about what has helped or hindered your community as you have participated in the activities associated with CHIP, the Community Health Improvement Partnership. My interest in rural community health has developed over the years that I have lived and worked in small towns throughout the West. I currently work in La Grande and live in the tiny farm community of Cove, and so I am aware of some of the unique strengths of rural communities as well as the special challenges they face in trying to address their health needs.

Community health development is a topic that has received quite a bit of attention in recent years. However, much of the work that has been done has focused on neighborhoods in large cities. As a result, little is known about what helps or hinders a rural community to plan and develop health programs. Knowing how rurality affects a community's ability to participate in a health development process is important in helping towns, such as yours, to have a positive and successful health planning experience.

The approach that I am taking in my study is based on the belief that rural people who have been involved in a health development effort can provide the best information about what helped, and what made it difficult, for their community to participate in this process. To obtain this information, I am planning to conduct a series of interviews in three of the communities that are involved in CHIP. Most of these interviews will be conducted one-on-one with people, such as yourself, who are knowledgeable about the CHIP project and the community's health delivery system in general. However, I will also need to conduct group interviews with members of the partnership team. Each of these interviews is expected to last approximately 2 hours. In addition, I will need to review documents pertaining to the community and the CHIP project (such as Chamber of Commerce materials and CHIP meeting minutes) and tour the rooms where the CHIP activities occur (such as the rooms where the partnership team meets).

If you are willing to participate in this study, I will ask you to assist me with several details. This will include helping me to identify people that may be appropriate to be interviewed, contacting these individuals to let them know about the study, scheduling two group meetings with the partnership team members, providing me with a tour of the areas used by CHIP, and giving me access to CHIP meeting minutes and a roster of members. In addition, I will ask you to set aside approximately 2 hours of your time so that I can interview you.

By participating in this study, you and other members of your community should gain a better understanding of the factors that assisted you to do health planning, as well as the factors that made it difficult to do health planning. This information will, hopefully, be useful to you as you engage in planning related to CHIP and future community improvement efforts. In addition, by participating in this study, you will be contributing information that may be helpful to other rural communities who decide to undertake a process such as CHIP.

On the other hand, it is recognized that participating in this study may be somewhat inconvenient for you and for other community members, and it is also possible that the study findings will reveal weaknesses in your community's planning process. In order to reduce the inconvenience for you and others, I will try to be very flexible in my schedule. To reduce the possibility that discovering a weakness in planning would create a problem for your community, the name of your community and the names of all persons interviewed will not be revealed. It is possible, however, that people who are very familiar with the CHIP program in Oregon will be able to recognize your community from the description that will be included in the final report.

Prior to the beginning of the study, I will meet with you to obtain your input into the questions that will be asked. Once the data have been collected, you will have an opportunity to review the preliminary findings and provide clarification or additional comments. After the study has been completed, I am hoping to publish the findings in a professional journal. I will also provide you with a summary of the findings and, if you would like me to give a presentation in your community to describe what was learned from the study, I would be happy to do this.

I will call you in about a week to answer any questions that you might have. If you are interested in participating in this study, I would like to schedule a time when we can meet in person to discuss this in more detail. I look forward to talking with you.

Sincerely,

Nancy Findholt, RN, MN
Doctoral Candidate

School of Nursing
Oregon Health & Science University
One University Blvd.
La Grande, OR 97850
1-541-568-4224 (home telephone number)

APPENDIX B

CASE STUDY PROTOCOL

I. Overview of case study project

A. Background

Within the past two to three decades, there has been a shift in thinking about how to improve the health of groups of people. We have seen a re-emergence of awareness that the health of individuals is not only determined by factors within the person (such as physiology, knowledge, and attitudes) but also by factors that are within the environment (such as interpersonal relationships, work site conditions, social norms, and public policies). At the same time, there has been a growing belief that if we are to create healthier environments, it is essential that community members be fully involved in assessing their health needs and in designing and implementing programs to meet these. Community involvement is, however, complex and difficult to achieve.

A community=s willingness to participate in health planning and the forms or levels of participation that are possible may be influenced by the physical setting, social structure, and culture of the community. A rural community, for example, has a physical setting and social structure that is quite different than an urban community and it may, as well, have a distinct culture. These factors B such as small size, familiarity among neighbors, and limited resources B may serve to either facilitate or hinder rural community participation in health development.

Knowing how rurality influences community participation is important if health professionals are to engage rural communities in health development initiatives, and if the communities themselves are to have a positive and successful health planning experience. This study, a doctoral dissertation, is intended to contribute to our understanding of this issue.

B. Study purpose and aims

The purpose of this study is to describe the influence of rurality on community participation in health development. The specific aims of this research are: 1) to examine how participation has been enacted in rural communities; 2) to identify factors within the culture of rural communities that hinder or facilitate participation in community health development; and 3) to identify factors related to the physical setting or social structure of rural communities that may hinder or facilitate participation in community health development.

II. Field Procedures

A. Gaining access

1. ORH Community Services Manager will contact CHIP coordinators to inform them of this study and to let them know that they will be contacted by the investigator.

2. A letter will be mailed to the coordinator describing the study.

3. The investigator will telephone each coordinator to discuss the study. If the coordinator appears willing to participate, a visit to the site will be arranged.

4. The investigator will meet with the coordinator. The purpose of this meeting will be to:

a. Provide an overview of the research and answer questions.

b. Obtain the coordinator's input into the questions that will be asked during the interviews.

c. Identify individuals who meet the key informant criteria; request that the coordinator contact the key informants to inform them of the study and the fact that they will be receiving a phone call from the investigator.

d. Select focus group participants from the partnership team members; discuss possible dates, times, and locations for the focus group interviews.

e. Obtain the coordinator's verbal consent for participation in the study.

5. Investigator will arrange for a toll-free telephone number.

6. After the key informants have been introduced to the study by the coordinator, the investigator will contact each of them via the telephone to:

   a. Describe the study and answer questions.
   b. Obtain verbal consent.
   c. Schedule a time for their interview.

B. General strategy for collecting data

   1. Gather documents before conducting interviews.
   2. Begin with Community A first because coordinator is resigning.
   3. Plan to spend three full days in each study site.
   4. Gather all the data from one site and complete "write-ups" and "contact summary sheets" before proceeding to another site.

C. Materials needed in the field

   tape recorder, tapes (60 min or less was recommended by Patton, 2002), lined paper, pens, laptop computer and floppy discs, file folders or manila envelopes for holding documents, change for paying for photocopying, extension cords, scotch tape, duct tape

D. Data to be retrieved from documents

   1. Demographic data (population size; population break-down by age, ethnicity, percent below poverty, and percent with high school diploma; average unemployment rate)
   2. Primary industries
   3. Distance from larger town
   4. Composition of CHIP partnership team by gender, age, ethnicity, and constituencies or organizations represented
   5. Evidence of community member input into decision-making (identifying needs, setting priorities, and planning programs) and which members are involved
   6. Frequency of meetings and regularity of members' attendance
   7. Number of activities undertaken by partnership team in past 6 months
   8. Population mobility patterns
   9. Percent of home ownership

10. Size of geographic area represented by CHIP
11. Availability of public transportation
12. Percentage of population who speak English less than "very well"
13. Number of civic organizations, service clubs, community associations
14. Number and variety of professional resources (lawyers, accountants, grant writers)
15. Number, size, type of local health care organizations

E. Observational protocol
    1. In each study site, observe and record the following relative to physical and structural barriers:
        a. Type and condition of roadways linking communities within CHIP service area and linking CHIP service area to larger communities
        b. Presence of geographic barriers that may impede travel
        c. Presence of sub-populations who may experience special barriers to participating in CHIP (e.g., ethnic minorities, persons with physical disabilities, those whose work may restrict participation)
        d. Presence of public transportation services
    2. In each study site, observe and record the following relative to community resources:
        a. Availability of technical resources (computers, Internet connectivity, fax machines, photocopiers, telephones)
        b. Adequacy of meeting rooms (note if accessible to individuals with handicaps; availability of restrooms, coffee makers, etc.; parking; blackboards, projection screens; degree to which quiet and comfortable)
        c. Adequacy of CHIP coordinator's work space, storage for documents.
        d. Presence of a designated space for CHIP activities; is this marked as such?

F. Study time line
    1. Summer 2003
        a. IRB approval
        b. Sites and individuals agree to participate
        c. Investigator incorporates CHIP coordinators= suggestions into the interview guide to the extent possible
        d. Data collection begins
        e. Thank you notes sent to key informants and to CHIP partnership team members following interviews
        f. Data analysis begins
    2. Fall 2003
        a. Data collection concludes

b. Thank you notes sent to key informants and to CHIP partnership team members following interviews

c. Preliminary study results are shared with CHIP coordinators and partnership team chairpersons who will have the opportunity to provide comments.

d. Data analysis continues

e. Study results begin to be written

3. Winter 2004
   a. Data analysis continues
   b. Study results continue to be written
4. Spring 2004
   a. Data analysis concludes
   b. Final results and conclusions written
5. Summer 2004
   a. Summary of findings provided to sites; investigator offers to make community presentation

III. Case study questions

A. Level 1: questions asked of interviewees (refer to interview guides, Appendix C).

B. Level 2: questions posed to the investigator and asked of each case

1. What kind of participation is occurring? Who is participating? How is participation occurring?

2. What is the priority assigned to health? In what ways, if any, has this influenced participation in CHIP?

3. Does the community believe that it has the ability to work together to solve community problems? In what ways, if any, has collective efficacy influenced participation in CHIP?

4. How do community members perceive the leader(s) of CHIP? Did the community's familiarity with the leader, or lack thereof, influence participation in CHIP?

5. How strong is the sense of community? How important is the community to the residents? What value do residents place on working to improve the community? In what ways, if any, did the sense of community and commitment to community influence community participation in the health development initiative?

6. Have certain people or sectors of the community been unable to participate in the health development process because of physical or structural barriers? Was participation in the health development initiative hindered because of physical or structural constraints?

7. To what degree is the community organized? What has been the community's experience with planning? In what ways, if any, did the level of community organization and experience with planning influence community participation in the health development initiative?

8. Are community leaders interested in and supportive of health? Do they invite the participation of a diverse network of residents? Are they willing to share power with others? Are leaders perceived as receptive to innovation and willing to address problems or use approaches that might be unpopular? Do they have skills in program planning and resource mobilization? In what ways, if any, did community leadership contribute to or hinder participation in the health development initiative?
9. What resources does the community have that can be accessed for health development activities? Was participation hindered in the health development initiative hindered because the absence of local resources?

C. Level 3: questions posed to the investigator and asked of the pattern of findings across cases
1. How has participation been enacted in rural communities?
2. Is the participation of rural communities in a health development initiative hindered because of limited support for health and health promotion?
3. Is community participation in health development facilitated by perceived efficacy of collective action?
4. Is rural community participation in a health development initiative influenced by whether the leader(s) is considered an "insider"?
5. Is participation of rural communities in health development facilitated because of a strong sense of community and commitment to community?
6. Is broad-based participation in rural community health development hindered because of physical or structural barriers?
7. Is the participation of rural communities in health development hindered because of limited social organization and experience with social planning?
8. Is rural community participation in a health development initiative hindered by the lack of effective leadership?
9. Does the shortage of professional, technical, and financial resources available to rural communities hinder participation in health development activities?

D. Level 4: questions asked of the entire study
1. How has participation been enacted in rural communities?
2. What factors within the culture of rural communities hinder or facilitate participation in community health development?
3. What factors related to the physical setting or social structure of rural communities hinder or facilitate participation in community health development?

E. Level 5: normative questions about policy recommendations and conclusions
1. How do the findings from this study contribute to what is known about community participation?

2. What do the findings from this study suggest for practitioners or researchers who are seeking to engage rural communities in health development initiatives?

IV. Outline of case study report

A. Audiences and effects

The primary audience for this report is my dissertation committee and the intended effect is to convince these readers of the report's worth, truth, and value. A secondary audience is the community of researchers. The goal in sharing the study's findings with other researchers is to heighten insight and add to existing information on the topic. The residents of the study sites are also a secondary audience. They will receive a summary of the study findings with the intended effect being to assist them in future planning.

B. Format

The format for the case study report will follow the general parameters established for a doctoral dissertation by the Oregon Health and Science University School of Nursing. The results will be presented in Chapters 5 - 8 and the findings will be discussed and interpreted in Chapter 9. The following outline for reporting is anticipated:

1. Chapter 5: Results for Case A
    a. Description of the study site
    b. Results of single-case analysis
2. Chapter 6: Results for Case B
    a. Description of the study site
    b. Results of single-case analysis
3. Chapter 7: Results for Case C
    a. Description of the study site
    b. Results of single-case analysis
4. Chapter 8: Cross-case Results
    a. Comparison of communities on demographic factors
    b. Cross-case findings pertaining to how participation was enacted
    c. Cross-case findings pertaining to community characteristics and how these influenced participation in CHIP
5. Chapter 9: Discussion
    a. Interpretation of findings from cross-case analysis
    b. Relationship between the findings and previous research as well as the conceptual model
    c. Theoretical and practical significance of the findings
    d. Limitations of the study
    e. Summary of the study

APPENDIX C

INTERVIEW GUIDES

Key Informant Interview Guide

Study: The Influence of Rurality on Community Participation in a Community Health Development Initiative

Date of interview:
Time:
Place:
Code for interviewee:

Introduction:

Thank you for agreeing to be interviewed. As I mentioned previously, I am in the doctoral program at the OHSU School of Nursing and the study that I am conducting is for my dissertation. The purpose of the study is to examine how rurality affects the ability of a community to participate in a health development process. I'll be asking you a series of questions about what has helped or hindered your community as you have been engaged in the CHIP process. I also plan to gather this same information from two other communities that are participating in CHIP. There are 29 sets of questions and I expect the discussion to take about 2 hours.

I'd like to remind you that this interview is confidential. Your name and your community's name will not be used in any of the reports nor will your answers be personally identified. It may be possible, however, for persons who are familiar with the CHIP program in Oregon to identify your community based upon the descriptive information that will be provided. I have a tape recorder with me and, with your permission, I'd like to record what you say. This will help to ensure that I don't miss any of your comments and it will also allow me to pay closer attention to what you are saying, rather than concentrating on taking notes. Is this okay?

Finally, I need to say that I'm here to learn from you. If, at any time, you think of a community characteristic that helped or hindered your community to participate in CHIP, please feel free to share this with me, even if it isn't included in the questions that I am asking.

Do you have any questions before we begin?

Questions:

1. I'd like to begin by asking a little about you. How long have you lived in (*community*)? What role did you play in getting the CHIP program started here? Have you been involved in other health planning efforts in (*community*) previously?

Form and Level of Participation

2. Where did the impetus for participating in CHIP come from? (In other words, how did your community come to be involved in CHIP?)

3. Could you describe for me the degree to which community members participated in the decision-making? In other words, I'm wondering to what extent the partnership team members or others in the community were involved in identifying local needs, setting priorities, and in planning the programs or activities. Was this level of participation one that local people were comfortable with? (Probe: Were community members asked to do too much? Or would they have preferred to have a greater role? Was some guidance and assistance needed?) What role did ORH play in this process?

4. What kinds of resources has your community given to support the CHIP activities? (By this, I am referring to the resources that have been given to support the planning process as well as those given to implement programs or activities.) (Probe: labor, money, materials, or information.) Would you say that these resources have been adequate/less than adequate/more than adequate to do the work of CHIP?

5. How many projects or activities has your partnership team planned (or implemented)?

6. How do you think the community as a whole (e.g., those people who are aware of CHIP) viewed this process of community health planning? What value did they place on it? (Probe: Was it viewed as being a worthwhile effort -- something that will help the community to address issues of importance? Or did most view it as not very meaningful?)

7. I've received a roster of the members which tells me their ages, genders, ethnicity, and the organizations or constituencies they represent. How does the diversity among the team compare to the diversity of the community as a whole? In other words, are all key sectors of the community represented on the partnership team? (Probe: Are target populations represented -- those who may have the greatest health needs? Ask if there are representatives from all regions of the area encompassed by CHIP.)

8. What kind of commitment did members invest in the partnership? (Probe: How much time do they commit to partnership activities? A lot, a moderate amount, a small amount? What has been the average tenure is on the partnership team?)

Now I'm going to ask you to describe certain characteristics of your community (by this, I mean the CHIP service area) and I would like you to consider how these characteristics may have helped or hindered community involvement in CHIP.

Sense of Community and Commitment to Community

9. How strong is the sense of community here? In other words, how strong is the sense of connection that residents feel toward their neighbors and to this area (the CHIP service area)? How integrated is the community? Is it relatively homogeneous or are there sub-groups within it? Is the population relatively stable or have people been moving in and out?

10. How do the residents feel about this community? In other words, how important is the community to them? How willing are they to work to improve the community?

11. Would you say that these feelings about the community affected your community's participation in CHIP? If so, how? (Probe: In terms of where the impetus for participation came from? Adequacy of resource contributions? Number and breadth of participants? Amount of time members were willing to commit? Whether participation was perceived as being meaningful? In any other ways?)

Perceived Efficacy of Collective Action

12. Would you say that most residents believe that, by working together, they can bring about improvements in the community? Would most residents believe that, by working together, they could actually improve the health of the community?

13. Did this belief affect your community's participation in CHIP? If so, how? (Probe: In terms of where the impetus for participation came from? Extent of participation in decision making? Resource contribution? Whether participation in CHIP was perceived as meaningful? In any other ways?)

Civic Organization

14. Are voluntary organizations such as civic/community organizations, church groups, school/parent groups, neighborhood associations, or sports or hobby groups popular here? Do most residents belong to some type of voluntary organization? Are these groups active in community affairs? Are there any groups that represent sectors that are at higher risk? (For example, is there a group that works on behalf of the elderly population, or is there a group representing migrant farm-workers?)

15. Did the presence/absence of active voluntary organizations affect your community's involvement in CHIP? If so, how? (Probe: In terms of level of participation in decision making? Number and diversity of members? Were there any representatives from voluntary organizations serving on the CHIP partnership team? In terms of whether local people had the knowledge and skills needed for planning? In any other ways?)

Priority Given to Health

16. I know that rural communities have many needs and concerns, and that health is only one of these. How does this community rank health in comparison to other important concerns? (Provide examples of others community concerns, if necessary.)

17. What are the major health-related interests/concerns in this community? (Probe: Is the community focused only on maintaining or expanding the health care system or is

there also interest in health promotion programs, such as programs to encourage exercise or to reduce smoking? If there is interest in health promotion, how is this ranked in comparison to other community interests?)

18. Would you say that the way your community prioritizes health in comparison to other concerns had an influence on the community's participation in CHIP? If so, how? (Probe: In terms of where the impetus for participation came from? Resource contribution? Diversity of membership? Whether participation in CHIP was perceived as meaningful? Any other ways?)

Leadership

19. The next question pertains to community leadership. By "leadership", I am referring to anyone in the community who is appointed to a leadership position or who is influential in community affairs (such as a business person or a clergy person). How would you describe the strengths and weaknesses of the local leadership as a whole in terms of:

- interest in health (e.g., concerned with community health problems, interested in programs that could improve health)?
- innovation (e.g., willing to take prudent risks)?
- boldness (e.g., willing to address problems or use approaches that might be controversial)?
- inclusiveness (e.g., do they seek to involve a wide variety of community members in various decisions)?
- management skills (e.g., problem solving, conflict resolution, program planning, resource mobilization)?

20. Would you say that the strengths or weaknesses of the local leadership had an effect on the community's participation in CHIP? If so, how? (Probe: In terms of impetus coming from within? In terms of involvement in decision making? In terms of number and diversity of members? In terms of scope of activities undertaken? In any other ways?)

Insider vs. Outsider Differentiation

21. Which individual(s) does the community think of as being the CHIP leader(s)? Is the leader(s) a community resident? If so, how long has the leader lived in the community? What is his/her role in the community? Is he/she someone who is considered to be a community "insider"?

22. Would you say that the community's familiarity with the leader, or lack thereof, influenced participation in CHIP? If so, how? (Probe: In terms number and diversity of members? Member time commitment? In any other ways?)

Resources

23. Here is a list of resources that may be useful in community planning and program development. (Provide list.) How would you describe the adequacy of local resources in terms of being able to carry out the work of CHIP?

24. How, if at all, did this affect participation in CHIP? (Probe: In terms of involvement in decision making? Resource contributions? Number of projects undertaken? In any other ways?)

Physical or Structural Barriers

25. Some communities have found that involving representatives from all key sectors in a health development initiative such as CHIP is difficult because of barriers that prevent or hinder certain sectors from participating in the meetings and activities. Are you aware of any barriers in your community that have prevented sectors of your community from participating? (Probe: inconvenient meeting times or time constraints; lack of childcare; distance, poor roads, or lack of transportation barriers; language barriers; other barriers?) Do you know if any actions were taken to reduce barriers so that people could participate? If so, what was done?

26. In your opinion, was the community's involvement in CHIP hindered in any way because of physical or structural barriers? If so, how? (Probe: In terms of number and diversity of members? Member time commitment? In any other ways?)

Experience with Social Planning

27. Has your community engaged in health planning efforts previously (before CHIP)? How about other types of social planning? What is your assessment of these previous planning experiences? (Probe if positive or negative.)

28. Did this history affect participation in CHIP in any way? If so, how? (Probe: In terms of level of participation in decision making? Number of members? In terms of whether local people had the knowledge and skills needed for planning? In any other ways?)

Final question:

29. The purpose of my study, once again, is to examine how rurality influences participation in a health development initiative. My own experience of living in a rural community has led me to believe that the characteristics of rural communities - both in terms of what they are like physically as well as what they are like culturally - could have an influence on community participation in a project like CHIP. In some ways, these

rural characteristics could serve to facilitate participation but, in other ways, they might make it more difficult for a community to effectively participate.

The insights and information that you have provided to me will be very useful as I try to sort this out. Can you think of any other characteristics that haven't already been mentioned that may have helped or hindered your community's involvement in CHIP? Do you have any final thoughts or lessons that you'd like to pass along?

Thank you very much for taking the time to answer my questions.

Focus Group Interview Guide

Study: The Influence of Rurality on Community Participation in a Community Health Development Initiative

Date of interview:
Time:
Place:
Code for focus group:

Introduction to the study and to the focus group process:

Thank you for agreeing to be interviewed. My name is Nancy Findholt and I am in the doctoral program at the OHSU School of Nursing. The study that I am conducting is for my dissertation. The purpose of the study is to examine how rurality affects a community's participation in a health development process. I'll be asking you a series of 12 questions about your community and its characteristics and then will ask you to consider whether these characteristics have helped or hindered your community to do the work of CHIP (to conduct health planning and to implement programs related to health). I also plan to gather this same information from two other communities that are participating in CHIP.

Before we begin, there are a few things that I need to review. First, I want you to know that the information you share with me will be used in my dissertation and may also be included in future publications or presentations. However, your names and the name of your community will not be used in any of the reports nor will your answers be personally identified. It may be possible, however, for people who are very familiar with the CHIP program in Oregon to identify your community from the descriptive information that will be included. Second, I need to let you know that I will be tape recording this discussion so that I am sure to capture all of your comments. Only I and my transcriptionist will listen to the tape. If anyone is uncomfortable with this, you do not need to stay for this interview. Also, you have the right to not answer any question if it makes you feel uncomfortable or you may leave the interview at any time.

The primary risks in participating in this study are that someone might recognize you or your community based upon the description of our discussion, the inconvenience you might experience because of this interview, and perhaps some discomfort in speaking in front of this group. On the other hand, I hope that, by participating in this study, you will gain information that may be useful in future planning efforts. Also, it is likely that your participation may also serve to benefit other rural communities who decide to undertake a process such as CHIP.

Once the discussion gets started, I am going to ask that only one person speak at a time. I'd like to hear from each of you, so I'll be encouraging everyone to talk about these topics. Please feel free to say what you think. There are no right or wrong answers to these questions B I'm simply interested in your thoughts and perceptions. If, at any time, you think of another community characteristic that helped or hindered your

participation in CHIP, please feel free to share this with me even if is has not been included in the questions that I am asking.

Finally, this discussion is expected to last two hours. If you've brought a cell phone or pager with you, I would appreciate it if you could turn it off, if possible, since it may be distracting. If this is not possible, I'd ask that you leave the room to respond to a call, and then return as quickly as possible. Thank you. Do you have any questions about what I have said?

Introduction to the questions:

When I use the word "participation", I mean that a group of people representing key sectors of a community are able to come together to identify their needs, make decisions, and take action to meet their needs. (Provide handout.)

Opening question:

1. I'd like to begin by asking a little about each of you. Can we go around the room and have each of you quickly tell me how long have you lived here and how you got involved in the CHIP project?

Thank you. Now I'd like to ask you some questions about your community. (By community, I mean the area represented that is included in the CHIP planning process.)

2. How strong is the sense of community here? (In other words, how strong is the sense of connection that residents feel toward their neighbors and to the community?) How willing are residents to work together to solve community problems?

3. Would you say that most residents believe that, by working together, they can bring about improvements in the community? Would most residents believe that, by working together, they could actually improve the <u>health</u> of the community?

4. Do you think that these values and beliefs affected your community's participation in CHIP? (In other words, did these values and beliefs affect the ability of your community to organize "a group of people representing key sectors of a community to come together to identify their needs related to health, make decisions, and take action to meet these needs"?) If so, how?

5. Are voluntary organizations such as civic organizations, church groups, school or parent groups, neighborhood associations, or sports or hobby groups popular here? Do most community members belong to some type of voluntary organization? Are these groups active in community affairs? Did the presence of these groups have an effect on the CHIP partnership team? Were the CHIP team members also active in other voluntary groups?

6. Every community has many issues to be concerned with, and health is only one of these. Where does this community rank health in comparison to these other important concerns? (Provide list.) Would you say that this had an influence on the community's involvement in CHIP? If so, how?

7. Tell me about your community's leadership. By "leadership", I am referring to anyone in the community who is appointed to a leadership position or who is influential in community affairs (such as a business person or a clergy person). How would you describe the strengths and weaknesses of the local leadership as a whole? Did the strengths or weaknesses of the leadership affect participation in CHIP in any way? If so, how?

8. Which individual(s) did the community think of as being the CHIP leader(s)? Was he/she someone who was considered to be a community "insider"? Did this influenced participation in CHIP and, if so, how?

9. Here is a list of resources that are useful in community planning and program development. (Provide list.) Would you say that your community had adequate resources in each of these categories to support the work of CHIP? What effect did this have on participation in CHIP? What effect has this had B or might it have - as you try to implement the CHIP projects?

10. Some communities have found that involving representatives from all key sectors in a health development initiative such as CHIP is difficult because of barriers that prevent or hinder certain sectors from participating in the meetings and activities. Are you aware of any barriers that may have prevented certain sectors of your community from participating? (Probe: inconvenient meeting times, lack of childcare, distance or poor roads; lack of transportation, language barriers.)

11. Has your community engaged in planning efforts prior to CHIP? Do you know if there were previous community health planning efforts? What is your assessment of these previous planning experiences? (Probe if positive or negative.) Did this history affect participation in CHIP in any way?

Summary and final participant comments:

12. The purpose of my study, once again, is to examine how rurality influences participation in a health development initiative. My own experience of living in a rural community has led me to believe that the characteristics of rural communities B both in terms of what they are like physically as well as what they are like culturally B could have quite an influence on community participation in a project like CHIP. In some ways, these rural characteristics could serve to facilitate participation but, in other ways, they might make it more difficult for a community to effectively participate.

The insights and information that you have provided to me will be very useful as I try to sort this out. Do you think that we've covered everything? Is there anything that was missed? Do you have any words of advice or lessons learned that you'd like to pass along to other communities who might be starting a health development process like this?

Thank you very much for your time and good luck to you as you continue your process of health planning and development.

APPENDIX D

HANDOUTS FOR KEY INFORMANTS AND FOCUS GROUP PARTICIPANTS

Handout for Key Informants:

Resource Categories

Professional resources (such as persons with expertise in planning, grant writers, lawyers, accountants)

Technical resources (such as computers, Internet connectivity, fax machines, photocopiers)

Physical resources (such as meeting rooms, offices, areas to store files and documents)

Financial resources (including local government budgets, local foundations, other sources of potential or actual support)

Staff support (secretarial and other staff assigned to the CHIP project; adequacy of their time and adequacy of their qualifications)

Handout 1 for Focus Groups:

Participation means that a group of people representing all key sectors of a community are able to

come together to
identify their needs,
make decisions, and
take action to meet their needs.

Handout 2 for Focus Groups:

Community Needs/Priorities

Education
Economic development
Arts and culture
Roads
Housing
Planning, zoning, and land management
Environmental issues

Handout 3 for Focus Groups:

Resource Categories

Professional resources (such as persons with expertise in planning, grant writers, lawyers, accountants)

Technical resources (such as computers, Internet connectivity, fax machines, photocopiers)

Physical resources (such as meeting rooms, offices, areas to store files and documents)

Financial resources (including local government budgets, local foundations, other sources of potential or actual support)

Staff support (secretarial and other staff assigned to the CHIP project; adequacy of their time and adequacy of their qualifications)

APPENDIX E

INFORMATIONAL LETTERS FOR KEY INFORMANTS AND FOCUS GROUP PARTICIPANTS

Informational Letter to Key Informants

August, 2003

Dear Community Leader:

I am writing to ask you to participate in a research study concerning the Community Partnership Improvement Partnership (CHIP). The purpose of this study is to explore how rurality influences the ability of a community to participate in a health development process. Specifically, I am interested in learning about what has helped and what has made it difficult for your community to participate in the activities associated with CHIP.

I am a graduate student at the Oregon Health & Science University School of Nursing and this study is part of the research required for my doctoral degree. My interest in rural community health has developed over the years that I have lived and worked as a nurse in small towns throughout the West. I currently work in La Grande and live in the tiny farm community of Cove, and so I am aware of some of the unique strengths of rural communities as well as the special challenges they face in trying to address their health needs.

Community health development is a topic that has received quite a bit of attention in recent years. However, much of the work that has been done has focused on neighborhoods in large cities. As a result, little is known about what helps or hinders a rural community to plan and develop health programs. Knowing how rurality affects a community's ability to participate in a health development process is important in helping towns, such as yours, to have a positive and successful health planning experience.

Most of the information that I intend to collect for this study will come from interviews. My plan is to conduct a series of one-to-one interviews with community members who are knowledgeable about the CHIP project and about the community's health care delivery system. In addition, I am planning to conduct two group interviews with members of the partnership team. Each of these interviews will last approximately 2 hours. I will also be gathering some information from documents and will be looking at the spaces and equipment that is used by the CHIP project in your community. The results of this study will be submitted for publication in a professional journal and your community will also receive a written report, summarizing the findings.

The primary benefits of participating in this study are that you and other community members will gain information that should be useful as you engage in planning related to CHIP and future community improvement efforts. In addition, by participating in this study, you will be contributing information that may be helpful to other rural communities who decide to undertake a process such as CHIP.

On the other hand, it is recognized that participating in this study may be somewhat inconvenient and that it is possible that the study findings will reveal weaknesses in your community's planning process. In order to reduce the inconvenience, I will try to be very flexible in the times that I schedule for interviews. Also, to reduce the possibility that discovering a weakness in planning would create a problem for your community, the name of your community and the names of all persons interviewed will not be revealed. It is possible, however, that people who are very familiar with the CHIP program in Oregon will be able to identify your community from the description that will be included in the final report.

If you agree to be interviewed, I will soon be phoning you to provide more information about this study and to schedule the time of the interview. In the meantime, if I can answer any questions, please feel free to telephone me at (*toll free number*) or at my office (*phone number)*. Thank you very much for your consideration of this request. I look forward to meeting you.

Sincerely,

Nancy Findholt, RN, MN
Doctoral Student
School of Nursing
Oregon Health & Science University
One University Blvd.
La Grande, OR 97850

Informational Letter to Focus Group Participants

August, 2003

Dear Community Leader:

I am writing to ask you to participate in a research study concerning the Community Partnership Improvement Partnership (CHIP). The purpose of this study is to explore how rurality influences the ability of a community to participate in a health development process. Specifically, I am interested in learning about what has helped and what has made it difficult for your community to participate in the activities associated with CHIP.

I am a graduate student at the Oregon Health & Science University School of Nursing and this study is part of the research required for my doctoral degree. My interest in rural community health has developed over the years that I have lived and worked as a nurse in small towns throughout the West. I currently work in La Grande and live in the tiny farm community of Cove, and so I am aware of some of the unique strengths of rural communities as well as the special challenges they face in trying to address their health needs.

Community health development is a topic that has received quite a bit of attention in recent years. However, much of the work that has been done has focused on neighborhoods in large cities. As a result, little is known about what helps or hinders a rural community to plan and develop health programs. Knowing how rurality affects a community's ability to participate in a health development process is important in helping towns, such as yours, to have a positive and successful health planning experience.

Most of the information that I intend to collect for this study will come from interviews. My plan is to conduct a series of one-to-one interviews with community members who are knowledgeable about the CHIP project and about the community's health care delivery system. In addition, I am planning to conduct two group interviews with members of the partnership team. Each of these interviews will last approximately 2 hours. I will also be gathering some information from documents and will be looking at the spaces and equipment that is used by the CHIP project in your community. The results of this study will be submitted for publication in a professional journal and your community will also receive a written report, summarizing the findings.

The primary benefits of participating in this study are that you and other community members will gain information that should be useful as you engage in planning related to CHIP and future community improvement efforts. In addition, by participating in this study, you will be contributing information that may be helpful to other rural communities who decide to undertake a process such as CHIP.
On the other hand, it is recognized that participating in this study may be somewhat inconvenient and that it is possible that the study findings will reveal weaknesses in your

community's planning process. In order to reduce the inconvenience, I will try to be very flexible in the times that I schedule for interviews. Also, to reduce the possibility that discovering a weakness in planning would create a problem for your community, the name of your community and the names of all persons interviewed will not be revealed. It is possible, however, that people who are very familiar with the CHIP program in Oregon will be able to identify your community from the description that will be included in the final report.

If you are willing to participate in the group interview, you will be contacted by *(CHIP Coordinator's name)*, who has agreed to schedule a place and time for this meeting. In the meantime, if I can answer any questions, please feel free to telephone me at *(toll free number)* or at my office *(phone number)*. Thank you very much for your consideration of this request. I look forward to meeting you.

Sincerely,

Nancy Findholt, RN, MN
Doctoral Student
School of Nursing
Oregon Health & Science University
One University Blvd.
La Grande, OR 97850

APPENDIX F

CONTACT SUMMARY SHEET

Contact Summary Sheet

Contact type
Key informant interview ___
Focus group ___

Site code ___
Interviewee/group code ___
Contact date ___________

1. What were the main themes or issues that emerged during this contact?

2. Summary of the information obtained (or not obtained) on each of the target questions:

Question	Information
Priority given to health	
Efficacy of collective action	
Insider/outsider	
Sense of community	
Physical/structural barriers	
Civic organization/planning	
Leadership	
Resources	

3. What was salient, informative, interesting in this contact?

4. What new ideas or hunches emerged?

5. What questions need to be answered relevant to this site?