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Community Health Diagnosis in Nursing

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Abstract A review of the historical evolution of the concept of community health diagnosis in nursing identifies sources of ambiguity that have impeded making the goals and values of community health nursing operational. Refinements of meaning in the conceptualization of the community health diagnosis that focus upon the community as the primary level of analysis are suggested. Implications of this reconceptualization of the practice of community health nursing are considered in guidelines for developing community health diagnoses and in an example of the diagnosis of a Mien refugee community's responses to health problems.

The basis of community health action must be an accurate assessment of the state of health of the community as a whole. For this reason, community health diagnosis is the keystone of community health practice (Freeman and Heinrich 1981, 314).

That community health diagnosis is an essential precursor to community health nursing intervention is widely acknowledged (ANA 1980; APHA 1980). Is reconsideration of the community health diagnosis an exercise in tautology? I say not.

Despite the chapters and texts that have been dedicated to community health nursing, we still have ambiguous definitions, unmeasurable goals, and a tenuous structure as guides for the construction and use of the community health diagnosis. The eclipse of community health diagnosis theory in the literature is so complete that some texts even exclude diagnosis as a stage of the nursing process applied to the community, and some subsume it under the rubric of community assessment (Archer and Fleshman 1979; Freeman and Heinrich 1981; Helvie 1981; Leahy, Cobb, and Jones 1982).

Assessment and diagnosis are, however, not synonymous. Attempts to make them so obscure diagnosis, which is the "keystone" of community health nursing practice, and in so doing, they neglect the commitment and specification that diagnosis signifies. Assessment refers to data collection and analysis, and is the first part of the diagnostic process. Diagnosis uses assessment as the basis for decision making and labeling that clearly and concisely describe a problem and imply its etiology (Critchley 1978): it completes the diagnostic process. By underplaying diagnosis in community health nursing, we risk losing the key with which to make operational the goals and values of the profession.

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This article reaffirms community health diagnosis as the fulcrum that balances data with programs in the practice of community health nursing. A review and critique of the concept lead into specification of its content and delineation of its structure.

A RETROSPECTIVE VIEW

The concept of community health diagnosis has evolved since World War II (McGavran 1956) from two major health disciplines, public health and nursing. Public health contributed a focus upon the group or aggregate as the unit of analysis, the goal of primary prevention, and the methods of epidemiology. Nursing supplied the decision-making context of health care and focused concern on the person as a social being rather than on the pathology of a human body.

The term community diagnosis was originally used in the 1950s by physicians (Cassel 1974; McGavran 1956; Clark 1965; Logan 1964). It was seen as a revolutionary application of the medical diagnosis of disease to *groups* instead of to individuals, that is, to "the community as an entity" or "the body politic" (McGavran 1956). The concept is grounded in medical epidemiology by its emphases on the morbidity and mortality experience of whole populations (including both sick and well members), and on environmental factors implicated in the etiology of the health problem. Its goals are fixed by the values of traditional public health: the prevention, control, and eradication of disease.

Application of diagnosis in nursing was also first made in 1950 (Miller and Keane 1983). Within some 20 years, its meaning and structure were codified by the nursing profession. The nursing process is a decision-making approach that is the fundamental intellectual and behavioral activity of nursing practice. It is comprised of five sequential steps: assessment, diagnosis, planning, intervention, and evaluation. Thus nursing diagnosis is the outcome of patient assessment and the prerequisite for planning patient care. A nursing diagnosis refers to human responses to actual or potential health problems that nurses are licensed to treat (ANA 1980b). Its structure is comprised of three components: (1) concise statement of a problem; (2) identification of factors etiologically related to that problem; and (3) statement of the signs and symptoms that are characteristic of that problem (Gordon 1976; Price 1980). Despite the pervasive presence of the nursing process in nursing practice and its declared relevance to community health nursing, there is as yet no analogous structure for a nursing diagnosis of community health.

Current understanding of community health diagnosis in nursing derives mainly from the works of Freeman (Freeman 1970; Freeman and Heinrich 1981, 314–315) and Hogue (1977). Both authors are primarily concerned with the nature of data required for valid and appropriate community health diagnosis of a specific population group. They derive a community health diagnosis from (1) assessing the health status, resources, and vulnerability of a community or population and its subgroups; (2) identifying the social and environmental factors associated with that health status, that is, patterns of health-illness relationships in the community; (3) evaluating the group's ability to deal with deficits in its health status; and (4) assessing and setting priorities of health goals and intervention options. The resulting diagnosis requires ongoing review and revision to accommodate new data that describe changes in the group, its health status, and its environment over time.

A CRITIQUE OF THE CONCEPT

While the concept of community health diagnosis has provided for a comprehensive data base at the level of the community, it is problematic because it lacks guidelines for distinguishing essential from nonessential data, and because it does not provide formats for constructing and specifying a community health diagnosis. Four sources of ambiguity are identified: (1) variation in the definition of health; (2) variation in the choice of the unit of analysis, with the range being from the individual as a member of the community at one extreme to the population at large at the other; (3) variation

among the three levels of prevention as the goal; and (4) variation in the definition of community.

The difficulties of defining health in social terms rather than in the medical term of the absence of disease are reflected in the definitions nurse authors have chosen. For example, Archer and Fleshman's (1979, 3) "optimal level of functioning" places similar emphasis upon functioning as Goeppinger, Lassiter, and Wilcox's (1980) "community competence" and Hall and Weaver's (1977, 5) "purposeful and integrated method of functioning within an environment." Skrovan, Anderson, and Gottschalk (1974) and Leahy, Cobb, and Jones (1982, 38), on the other hand, espouse models of health as fitness in adaptation to stress. Variation in the definitions of health also reflects the systems theory orientation that underlies community health nursing (Freeman and Heinrich 1981, 42–44; Hall and Weaver 1977, 5; Hanchett 1979; Helvie 1981, 3–109). Systems theory sanctions the collection of almost any datum because it is part of the system and therefore potentially useful (Glittenberg 1982). The effect on the community health nurse and even on the field of community health nursing itself can be distraction by the irrelevant, disorientation by camouflaging detail, and suffocation of morale and vision by data overload (Shamansky and Yanni 1983).

Other problems in conceptualizing community health diagnosis pertain to differences within the nursing profession about the relative focus upon the individual versus the community at large, and upon curative versus preventive care. These differences have polarized into conflicting paradigms within the field of community health nursing. They can be clarified by comparing the recent statements of the two major professional organizations: the American Nurses' Association's (ANA) Division of Community Health Nursing (1980) and of the American Public Health Association's (APHA) Public Health Nursing Section (1980a).

The former has defined community health nursing as involving "management of the health care of individuals, families, and groups in a community" (1980a). This allows for nursing care of individuals and families on a case basis. It focuses upon the individual or family as the unit of nursing analysis and practice as a means of improving the overall health of the community. For example, when faced with the risk of low-birth-weight infants among teenage mothers, an "ANA nurse" would assess the dietary beliefs, knowledge, and behavior of each pregnant teenager in her caseload; she would then provide relevant education on nutrition and on adolescent and fetal development, and link each of the young women to appropriate services in the community to help them obtain an adequate diet.

The APHA's Public Health Nursing Section's definition focuses primarily on the community level: "Emphasis is on . . . a community as a whole rather than on individual health care" (1980). It allows nursing care of individuals or families insofar as they are thought of as members of groups at risk of illness or poor recovery. The group/community/population is identified as the unit of analysis and of nursing practice on the assumption that improved health status of the community as a whole will benefit all of its members. In comparison with the above example, an "APHA nurse" would first identify the size of the teenage population and the rates of teenage pregnancy in her community; her intervention would be focused on change at the community level. She would assess dietary resources in places where teenagers congregate and arrange to substitute nutritious snacks for junk food in school vending machines and cafeterias, or work politically to get food supplements for low-income pregnant women.

A related problem in conceptualization of the community health diagnosis is a variation among the three levels of prevention* as the goal of community health nursing practice. Different

**Primary prevention* refers to the prevention and reduction of health risk; *secondary prevention* refers to the reduction or elimination of pathology; *tertiary prevention* refers to rehabilitation or the enhancement of social functioning when the disease process has been terminated or otherwise controlled (Leavell and Clark 1965).

paradigms influence the profession. For example, the ANA (1980, 13) definition places equal emphasis upon all three levels of prevention. The APHA (1980, 2) definition, in contrast, is predominately concerned with the primary level of prevention. Since the goals of nursing care and states of health are different in each level (Shamansky and Clausen 1980), the scope and substance of the community health diagnosis vary accordingly.

The fourth problem in interpreting the community health diagnosis is the numbers of definitions of community. Even those for whom the community is the focus of nursing practice require broad and flexible terms (APHA 1980; Archer and Fleshman 1979, 21; Freeman and Heinrich 1981, 38; Goeppinger et al. 1980; Hogue 1977, 97; Tinkham and Voorhies 1977). One problem is that the boundaries of a given community are difficult to delineate because of its interrelatedness with its subsystems, suprasystems, and peer systems (Weaver 1977, 164). Another problem is the tendency to use a variety of terms as synonyms: thus "community," "public," "population," and "group" are often used interchangeably even though they carry different meanings in the vocabularies of the social sciences.

Some definition, however, is prerequisite to assessment of a community's health status. Although a majority of nurse authors cite shared physical environment as a limiting characteristic of community (Goeppinger 1980; Moe 1977; Shamansky and Pesznecker 1981), some do not, using instead, common interest, solution, emotion, or risk (Archer and Fleshman 1979; Leahy et al. 1982; Weaver 1977, 163; Williams 1977; WHO 1975). Such variation permits flexible response to an increasingly complex health care environment, and acknowledges that any one person or household is simultaneously a member of more than one community. The variation has several disadvantages, however. It obstructs implementation of the practice of community health nursing at the level of the community, and it restricts both the ability to generalize findings from one community to another and to compare community health diagnoses across communities.

The conceptual problems with the community health diagnosis are not unique to nursing. They reflect several developments in the interpretation of health across the related disciplines, including the social sciences. Problems of definition are pervasive. Although research in large populations has brought new appreciation of the close association between health status and both environmental factors and personal choices about lifestyles (Kessler and Levin 1970), the meanings of health status, environment, and lifestyle have simultaneously expanded in complexity and scope (Elinson, Mooney, and Siegmann 1977; LaLonde 1974; Surgeon General 1979).

Ethical implications associated with either the individual or the community pose other problems, since the levels of analysis are different and can conflict. For example, when the individual is the unit of analysis, he may be held responsible for his health status: this is the tenet taken by the school of self-care proponents (Levin 1978; Norris 1979). When the community is the level of analysis, however, society may be held responsible for its health status (Beauchamp 1975; Dreher 1982; Ryan 1971). It is essential to identify where this responsibility is vested because those so identified will be the targets of nursing interventions. Political and economic constraints also form a problem area that impedes conceptualization of community health diagnoses. For example, although growing numbers of health care providers are convinced of the wisdom of prevention relative to the costs in suffering and money of the customary care/cure approach of personal health care (Robbins and Hall 1970), funding for preventive care has lost favor under the current administration, thereby impeding development of concepts and practice in this area.

In spite of all these problems, one growing trend among authors in community health nursing can be observed. This is the application of the epidemiologic approach to assess the health status of communities to promote primary prevention (Dever 1980; Faber and Reinhardt

1982; Hanner 1980, 148). In the next section, I propose a model for derivation of the format for constructing a community health diagnosis that is grounded in this approach and structured by the format of nursing diagnosis. It is done in a systemic way to help mitigate the problems previously discussed.

A PROSPECTIVE VIEW

Renewed emphasis upon community health diagnosis focuses on the community as the primary level of analysis. The implications affect the goals of nursing practice, unit of analysis definitions of community, and methods of practice.

Goals of Nursing Practice

Community health nursing can be differentiated from clinical nursing in several ways that affect the content of community health diagnosis. One major area of difference is that the goal of community health nursing is primary prevention. Clinical nursing's goals, in contrast, are primarily to restore an individual's health, limit the patient's disabilities, or make an inevitable death as comfortable and dignified as possible. These involve secondary or tertiary prevention (Leavell and Clarke 1965, 21). Community health nursing is a form of prospective health care in that it aims to control threats to health before signs of overt pathology are detectable (Shamansky and Clausen 1980). Nevertheless, it may include retrospective care, the predominant mode of clinical nursing, which focuses upon the treatment of known health deficits (Robbins and Hall 1970), just as clinical nursing may include primary prevention in the care of individual patients. The theoretical reason for this overlap is that health and disease may coexist in the same individual or in the same population.

Unit of Analysis

Community health nursing integrates the epidemiologic approach with the nursing process to make fundamental decisions about care at the level of the population as a whole. This means that the unit of concern includes not only those who seek care, as is the case in clinical nursing, but those who do not. The segment of the population that has not received care is included to establish how common or rare are the health problems or needs of the care receivers, to determine if the nonreceivers need or want care and the reasons they have not obtained it, and to provide for health maintenance among the whole population. The case-finding tradition of public health nursing is consistent with this concern for persons who need but have not received care.

Definition of Community

For purposes of this article, the term community refers to a "bunch" of people who are related by at least one common characteristic that justifies their being considered a single client system by the community health nurse. The ways in which the people in a given community are related to each other must be specified by the nurse so as to develop a community health diagnosis of them and to allow for comparison among communities. The word population refers to an aggregate that may include any number of communities.

Methods

Epidemiology provides concepts and methods for estimating which segments of the population are most likely to experience disease and mortality in the future. These methods, called risk assessment, enable the nurse to identify groups at risk (i.e., potentially susceptible to a specific condition) or at high risk (i.e., having at least one known risk factor for a specific condition), and then to design interventions to lower their risk status and promote their health (Freeman and Heinrich 1981; Hanner 1980, 148; Lauzon 1982; Leppink 1982; Williams 1977). Conduct of risk assessment by community health nurses is, however, not limited to a definition of risk by disease or death. It also includes risk of premature, prolonged, or unsuccessful developmental experiences such as puberty, pregnancy, and old

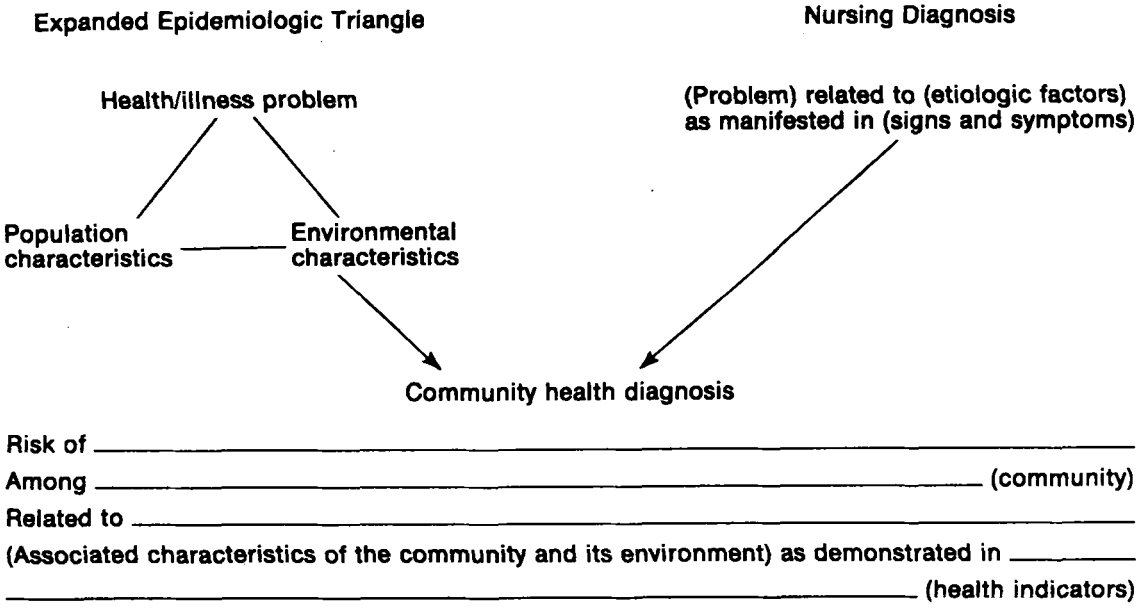

Figure 1. Derivation of the Format for the Community Health Diagnosis

age, as well as risk of reduced health, as associated with social isolation, for example. Assessment involves description and analysis of the community's demographic and environmental characteristics in terms of epidemiologic risks that are defined for larger aggregates. The description is used as the basis for inferring health risks for the community from the larger population.

To describe its characteristics accurately, the nurse becomes directly involved with the community. This can be achieved through home visits, on-site assessments of community agencies and industries, participation on service organization boards, and reading community newspapers and other methods of study (Arensberg and Kimball 1967). Familiarity with prevalent lifestyles facilitates identification of health risks threatening the community.

Format

A proposed structure for community health diagnosis combines the format of the nursing diagnosis with that of the expanded epidemiologic triangle (Figure 1). The community identified is the one whose health risk needs to be lowered.

THE DIAGNOSTIC PROCESS

The formulation of a community health diagnosis in nursing begins with the following steps to identify the community of concern:

1. Identification of health risk in the community
   a. Identify the community and the basis for defining it as such (if the diagnostic health risk is already known, go to 2)
   b. Identify demographic and environmental characteristics
   c. Identify the health risks that are associated with the characteristics identified in b
   d. Determine criteria to establish priorities of risks for subsequent nursing intervention
   e. Determine a weighting scheme to assess the value of each risk according to the criteria set in d
   f. Add the scores to select the risk with the highest score for the stem of the diagnostic statement

TABLE 1. *Derivation of the Health Risk Component of Community Health Diagnosis from Descriptions of the Community and Its Environment: Categories of Relevant Data for Initial Assessment*

Community Characteristics ⟶	Health Risks	⟵ Environment Characteristics
Age range and mode Gender ratio Ethnic composition Socioeconomic level Employment status Educational background Marital status	Any cause of death or type of disability, morbidity, developmental stage, in appropriate behavior associated with any of the population or environment characteristics listed	Available health care resources Transportation, education, and recreational resources Population density Sources of stress Safety measures Air, water, or noise pollution Sources of social support Distribution of decision-making power
Plus any special characteristics of the population of concern		Plus any special characteristics of the population's environment

The examples given are indicative rather than exhaustive.

2. Specification of the characteristics of the community and of its environment that are etiologically associated with the risk
3. Specification of the health indicators that verify the risk

This is analogous to formulating the nursing diagnosis in clinical nursing, which begins with identification of the patient. The characteristics of the population that make it a community should be described to allow for comparison with other groups (Archer and Fleshman 1979, 22–29; Shamansky and Pesznecker 1981). The defining characteristic of a population may be a shared health risk.

Once the community is defined, its social and environmental characteristics are described so that associated health risks can be identified (Table 1). Aggregate-level descriptors such as health indicators (age- and cause-specific morbidity and mortality rates, health service use rates, sanitation facilities, safety resources) and social indicators (socioeconomic status, employment status, educational status, crime and delinquency rates, recreational resources, etc.) can be obtained from public records to begin the descriptions. Useful sources of such data include the census, vital statistics, National Center of Health Statistics' survey reports, Centers for Disease Control publications, and National Safety Council reports. Community-specific data can be obtained through the literature on salient characteristics of the population, key informants, surveys, nurse observations and interviews in situ, or the community's own records or publications.

When it is felt that the major health risks and their associated community characteristics have been identified, one risk is selected for each community health diagnosis. First, criteria are stipulated for selecting one risk from the roster. These usually include appropriateness to the community health nursing role, prevalence of the risk in the community, severity of the risk, potential for risk reduction, the level of the community's interest in reduction of the risk, and availability of appropriate resources (personnel, money, equipment, space, time, etc.). Next, a weighting scheme by which to assess the value of each health risk for each criterion is formulated (e.g., 0 = no priority; 1 = some priority; 2 = high priority) and the scores are totaled. The one with the highest score is the risk of choice for the community health diagnosis

TABLE 2. *Example for Identification of Health Risk from Descriptive Data: Mien Refugee Community*

Community Characteristics	Health Risks	Environment Characteristics
Ethnicity: Mien from Laos	1 accident from fire	Immediate environment
8 in refugee camps 2–7 yrs before coming to USA 2 mos-3 yrs ago	2 crime victimization	2,4 High-crime urban residential area: thefts, vandalism, rapes
Size: 92 in apt. bldg; about 1,000 in city	3 respiratory infections	Low-income, ethnically mixed area, much
5 Age: 91% <45 yrs of age;	4 depression, suicide	2,6 ethnic tension, little
3,10 50% < 15 yrs of age	5 marital stress, spouse abuse	4,8 interethnic communication
Occupation: skills in mountain farming, military, embroidery;	6 disaster in emergencies	Mien rent 17 of 19 apts. in rundown bldg.: walls and ceilings cracked,
4,5 most unemployed	7 inappropriate health care	2,3 windows broken, paint peeling, bathrooms not ventilated, roaches and mice dense in bldg
Education: few had formal ed in Laos	8 inappropriate health care seeking	1,3 Crowding: 3-9 people 1-bedroom apt
4.5 Income: ⅗ get food stamps; ⅖ get cash assistance	9 inadequate health care	2 Bldg. and apt. doors not
2,4 Language: most are prelit-	10 teenage pregnancy	2 locked; no peepholes in doors;
5,6 erate, adults speak		2 Laundry several blocks away
7,8 minimal English, school-children speak English		1 No smoke alarms
9 Religion: previously animist; strong recent converts to Christianity		1 Clothing dried near electric wall heaters
Family: strong extended family cohesion, patrilineal organization;		Telephones in 80% apts.
10 children strongly desired; elderly highly respected;		Convenient bus service
4,5 conflicts over spousal and intergenerational role reversals		Mien vegetable garden vandalized
2 Behavior norms: nonaggressive, respectful, quiet		Larger city environment
1,2 Culture gap: unfamiliar		7,9 Few Mien interpreters; free dental services up to age 19 yrs,
4,6 with safety measures and with community resources		9 none over 18 yrs
8,9 Health: little medical		Health dept. performs physical screenings and referrals on refugee arrival
10 care or experience with biomedicine; fear of		Community clinics provide care on sliding fee basis
8,9 surgery and blood drawing;		9 Hospital costs usually not covered by programs for which Mien eligible
9 no dental hygiene; high prevalences of		4 High unemployment rate
7 lactose intolerance,		2,6 English language train-
7 IHN resistance,		7,8 ing programs too short
9 anemias related to GI parasites or blood dyscrasias, depression, and suicide; most women multiparous;		A forum of refugee service agencies and gov't offices well established
8,9 belief that illness is caused by spirits		Active Mien church
Nutrition: babies bottle-fed; elderly edentulous;		
7,9 try to balance hot and cold foods, avoid cold foods postpartum		

Numbers indicate inferred associations between a characteristic of the population or environment and the designated health risk. Note that each health risk is associated with more than one characteristic.

TABLE 3. *Example for Selection of Health Risk for a Community Health Diagnosis*

1. List identified health risks
2. Decide on criteria
3. Decide on a weighting scheme
4. Assign weights to each cell
5. Tally totals for each health risk
6. Highest score indicates risk of choice

Health Risks	Criteria*							
	Appropriate for CHN Role	Prevalence of Risk	Severity of Risk	Potential for Risk Reduction	Community Interest†	Expected Duration of Program Effects	Availability of Resources	Total Score
Fire accident	2	2	2	2	4	2	2	16
Crime victim	2	2	2	2	4	2	2	16
Respiratory infections	2	2	1	1	2	1	1	10
Depression, suicide	2	2	2	1	4	1	0	12
Spouse abuse	2	2	2	1	0	?‡	0	7
Disaster in emergency	2	2	2	2	2	2	2	14
Inappropriate health care	2	2	2	1	2	1	1	11
Inappropriate care seeking	2	2	2	1	0	1	1	9
Inadequate health care	2	2	2	0	2	0	0	8
Teen pregnancy	2	2	2	1	0	0	1	8

*Weighting schema: 0 = no priority; 1 = some priority; 2 = high priority.
†This column was double weighted to emphasize the importance of community interest in making a community health diagnosis.
‡Undeterminable.

(Tables 2 and 3). The remaining risks may be phased into other community health diagnoses in like fashion.

The diagnosis is completed by selecting the associated characteristics that are amenable to modification through community health nursing intervention and by identifying the health indicators that verify the specific risk. An example of the process of formulating a community health diagnosis follows.

AN EXAMPLE OF THE DIAGNOSTIC PROCESS

Several caseworkers and interpreters in the city had asked if community health nursing students would look into problems that Mien refugees from Laos were having in their apartment buildings.* They were specifically concerned about broken windows and equipment, and poor sanitation.

Together with a Mien interpreter and the Mien manager of one of the apartment buildings, the nursing students defined their community as the 17 households of refugees living together in the building. There were two non-Mien, non-refugee households in the building; after meeting with them and discussing their interest in the problems, the students decided to exclude them from the target community for the following reasons: "They have different needs, and do not socialize with the Mien people. They share the environment, but not the activities, language, or goals of the Mien residents." The Mien residents, in contrast "shared a language, a culture, and a flight to freedom. They have shared a war and the loss of kin and homeland. They share the experience of being different from most members of the society of which they are becoming a part" (Woo et al., 1982). The immediate target group thus comprised a community by virtue of common physical and social environment, history and social status, difficulties in survival, and goals.

*The example derives from my work with seven senior nursing students in the ten-week nine-credit course in community health nursing at the University of Washington (Woo et al. 1982).

Data were gathered on the immediate Mien community by household census survey, interviews with key informants (the apartment manager, a Mien interpreter from the health department, and an anthropologist), and by open-ended interviews during home visits carefully scheduled at different times of the day and week so as to gain familiarity with the group's lifestyle. In addition, the apartment manager and his brother conducted a brief health survey of the Mien residents. Data on Mien in the rest of the city and on refugees of other origins in the city and state were obtained from key informants and the literature. Some of the data are shown in Table 2, together with a partial list of health risks that were inferred from the descriptive data. Compilation of the lists generated questions and searches for more data. The list provided here exemplifies the process; it is not a comprehensive description.

Ten health risks were associated with specific characteristics of the Mien community and its immediate and larger urban environments (Table 2). Priorities of these risks were established according to seven criteria, against which each risk was weighted (Table 3). The highest score indicated the risk of choice for a community health diagnosis of the community. In this case, two health risks received the top score. Community health diagnoses for each could be phrased as follows:

1. Risk of fire accidents among the Mien community renting apartments at — X Street, related to
   a. Unsafe use of heaters
   b. Lack of smoke alarms
   c. Unfamiliarity with fire safety protocols (escape routes, fire drills, calling the fire department)
   d. Minimal level of English language skills as demonstrated in
      (1) High incidence of fires starting from clothing or bedding near electric wall heaters in the city
      (2) Greater severity of fires not detected early.
      (3) History of delaying calls for help in crises until a Mien who speaks English well is contacted.
2. Risk of being vandalized, robbed, or raped among the Mien community renting apartments at — X Street, related to
   a. Unfamiliarity with means of self-protection (locking doors, letting strangers in apartment, etc.)
   b. Unfamiliarity with community resources (tend to associate police with the military rather than with citizen protection)
   c. Fear of causing trouble to others (by reporting them to police) in a country where they have already received much help
   d. High-crime, high-unemployment, high-poverty neighborhood
   e. Difficulty giving information officials need in English as demonstrated in
      (1) Apartment windows repeatedly broken, vegetable garden littered with glass and refuse
      (2) Refugee reluctance to call police for help
      (3) High rate of rape attempts on refugee women

CONCLUSIONS

The diagnosis sets the groundwork for community health nursing's goal of reducing health risks by identifying them and the factors that appear to sustain them. The example given shows how decisions about community health nursing's commitment to primary prevention at the level of the group can be established in clinical practice.

The example also shows that the word "community" can take on a methodologic as well as a conceptual definition in the formulation of a community health diagnosis. The method (Arensberg and Kimball 1967) requires that the nurse be directly involved with the community to collect accurate and relevant data. The method also requires that the community be directly involved in data collection and analysis. Such par-

ticipation is necessary to safeguard the community's ethical rights to control information on itself, to reduce its sense of vulnerability and increase its sense of competence, and to promote the chances of successful implementation of a program to reduce the identified health risk.

Incorporation of the community health diagnosis model into nursing education might be done differently at the baccalaureate and master's degree levels. For instance, the example of the refugees is appropriate for baccalaureate level students' introduction to community health nursing because the community has clear boundaries, is fairly homogeneous, and has expressed a health need. High-risk subgroups within the Mien community also could be identified from the descriptive data collected: the elderly, teenagers, and the unemployed. These people could be screened for case finding and follow-up at the level of the household. By working simultaneously at both household and community levels in the same community, the student has opportunity to observe and participate in two areas of the social system that influence the community's health risks.

In master's degree programs, the community health nurse works at a level of greater complexity. For example, the target community could consist of one or more of the ethnic groups in a large urban neighborhood or with all refugees in the city. Health risks among the subpopulations would be assessed, and the variation in size of relative risks among them would be examined. The principle of justice as fairness, whereby limited resources are allocated equitably, would become an important criterion for setting priorities of health risks for the community health diagnosis. The systems depth of the community would involve many strata, from complex to progressively more homogeneous units down to the household. The nurse would thus be educationally prepared to work at the supervisory level in a community health nursing setting.

By describing and exemplifying the diagnostic process in community health nursing, and by focusing it on the goal of primary prevention at the level of the community, the community health diagnosis is reconfirmed as the keystone of community health nursing practice.

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