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# Community Health Nursing Advocacy: A Concept Analysis

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The purpose of this article is to present an in-depth analysis of the concept of community health nursing (CHN) advocacy. Walker and Avant's (2010) 8-step concept analysis methodology was used. A broad inquiry into the literature between 1994 and 2014 resulted in the identification of the uses, defining attributes, empirical referents, antecedents, and consequences, as well as the articulation of an operational definition of CHN advocacy. Model and contrary cases were identified to demonstrate the concept's application and to clarify its meaning. This analysis contributes to the advancement of knowledge of CHN advocacy and provides nurse clinicians, educators, and researchers with some conceptual clarity to help improve community health outcomes.

Community health nurses practice in diverse settings. The nature of advocacy will, therefore, be different in the multifarious contexts in which nurses practice (Mardell, 1996). The health care landscape in the United States is changing due to factors such as the changing demographic trends, implementation of the Affordable Care Act, and early discharges from hospitals to community settings. Community health nurses are encountering more complex health and social issues among high-risk vulnerable populations in different communities. Promoting and supporting upstream community-based interventions is therefore central to community health nursing roles.

The primary purpose of this article is to analyze advocacy in the context of community health nursing (CHN) practice by identifying the uses, defining attributes, empirical referents, antecedents, and consequences using Walker and Avant's (2010) concept analysis techniques. Furthermore, *advocacy* is used frequently in nursing, other allied health professions, and in other disciplines as a catchphrase for support, aid, or assistance rendered to clients, thereby generalizing its use. A secondary purpose of this article is to clarify the meaning and develop an operational definition of CHN advocacy. This helps nurses to be thorough and systematic in their efforts to improve clients' health outcome.

## BACKGROUND

Advocacy has been examined by several scholars in different contexts, such as in pain management (Vaartio, Leino-Kilpi, Suominen, & Puukka, 2008), cancer care (Hagan & Donovan,

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2012; McCorkle et al., 2011), case management (Tahan, 2005), and health promotion (Gould, Fleming, & Parker, 2012). Many health-related concept analyses have also been conducted and documented, such as patient participation (Cahill, 1996), social justice (Buettner-Schmidt & Lobo, 2011), physiological stability (Lebel, Alderson, & Aita, 2014), self-advocacy and cancer (Hagan & Donovan, 2012), and patient advocacy (Baldwin, 2003; Bu & Jezewski, 2007). Scholarly literature on the concept analysis of CHN advocacy is lacking. This article fills this gap.

Much of the scholarly literature used in this analysis referenced CHN and public health nursing (PHN). PHN is the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (American Public Health Association Public Health Nursing Section, 2013). CHN is broader and combines public health and nursing knowledge and skills to address the health needs and problems of communities and vulnerable populations (Allender, Rector, & Warner, 2010). Both CHN and PHN focus on population health and utilize advocacy principles. Therefore, they are used interchangeably in this analysis. To situate advocacy in the context of community health, its theories, history, and definitions will be explored.

Several scholars developed theories of advocacy. For example, Curtin's theory of human advocacy states that the aim of advocacy is to assure the welfare of human beings, because nurses and patients share a common humanity (Curtin, 1979). Gadow's existential advocacy (developed in 1980) focuses on the patient's choice—nurses assisting patients to clarify their values, and to authentically exercise their freedom of self-determination (Gadow, 1990). Kohnke's functional model focuses on informing patients about their disease processes, treatments, medications, and procedures, and "placing the responsibility of decision making where it belongs, in the patients' hands" (Kohnke, 1982, p. 171). Fowler (1989) proposed a social advocacy theory that integrates the values of the work of Curtin, Gadow, and Kohnke by focusing on the social justice aspect of advocacy. Not only do nurses advocate for patients at the bedside, they also advocate for change within and across institutions, communities and societies.

Bu and Jezewski (2007) presented a mid-range theory of patient advocacy by synthesizing the four models of Curtin, Gadow, Kohnke, and Fowler into a unified theory with three core attributes: (a) safeguarding patients' autonomy, (b) acting on behalf of patients, and (c) "championing social justice in the provision of health care" (p. 104). They emphasized that advocacy takes on the role of social justice in providing adequate health care for all people. Although advocacy is often connected to patients' rights such as patients' right advocate, Gaylord and Grace (1995) asserted that patient advocacy is not merely the defense of infringements of patient rights, but rather stems from a philosophy of nursing in which nurses support individuals to promote their own well-beings, as understood by those individuals.

Over the centuries, nurses advocated for people and communities in need, as reflected in the work of early nurse pioneers. Public health nurses in the 19th and 20th centuries dealt with many of the same community health advocacy threats that practitioners face today, such as poverty, communicable diseases, poor housing, lack of access to health and social services, and inequitable access to family planning information (Allender et al., 2010). For example, Florence Nightingale pursued environmental health advocacy and health reform, particularly for British soldiers (Falk-Rafael, 2005); Lillian Wald advocated for home health nursing programs, the reform of child labor practices, and workplace protections (Allender et al., 2010); Margaret Sanger fought for access to birth-control information and services by vulnerable and underserved populations

(Allender et al., 2010; Weatherford, 1994); and Mary Seacole, although beset by racism, cared for and advocated for soldiers and those with infectious diseases such as cholera (Allender et al., 2010). These nurses were not only in communities working with vulnerable populations, they also pushed for policy changes at the systems level.

*Advocacy* is derived from *advocate*, and both concepts are often used interchangeably in nursing education and practice. Advocacy has been defined by many scholars from different backgrounds to include: the act of arguing on behalf of a particular issue, idea, or people (Ingram et al., 2008); coordinating and intervening with the system on behalf of the client (Chafey, Rhea, Shannon, & Spencer, 1998); pleading the case of another or championing a cause (Allender et al., 2010); seeing a need and finding a way to address it (Amidei, 2010); empowering those that are less able to present their views or needs, with the goal of giving them a voice and/or achieving their objectives (Allender et al., 2010); and taking a position on an issue, and initiating actions in a deliberate attempt to influence private and public policy choices (Labonte, 1994). R. Hanks (2012) also described advocacy as a therapeutic relationship and communication between the nurse and the patient.

A patient or nurse advocate has been defined as one who acts as a liaison that bridges the communication gap between patients, the health care system, and health care providers to help improve or maintain a high quality of health care for the patients by protecting patients' rights (Bollard, 2009; R. Hanks, 2012); moderates between the patient and the health care setting (O'Connor & Kelly, 2005); and has a responsibility for "appropriateness and coordination of care" for an individual patient or community (Staines, 2009, p. 8). Because an advocate engages in advocacy work, both *advocate* and *advocacy* are used synonymously in this analysis.

Walker and Avant's (2010) eight-step concept analysis methodology was used for this analysis. The steps are as follows: (1) select a concept, (2) determine the purpose of the analysis, (3) identify all uses of the concept that you can discover, (4) determine the defining attributes, (5) identify a model case, (6) identify additional cases (contrary case), (7) identify antecedents and consequences, and (8) define empirical referents. Steps 1 and 2 were discussed in the introduction. Steps 3–8 are discussed in the following in an order that allowed for a logical flow of the analysis.

Although Walker and Avant's (2010) eight-step approach is very laborious, it was utilized because it was a pragmatic framework that allowed the author to analyze the concept in an expansive way so that nurse researchers, educators, and clinicians can grasp the various elements of the concept to understand how it operates in different contexts. Furthermore, the approach provided a structure that enabled the use of theories of advocacy to break down and understand the meaning of the concept, as well as to identify its attributes. It also helped to develop an operational definition of CHN advocacy that reflects its theoretical base.

## DATA SOURCES

An extensive review of the literature was done by searching PubMed, CINAHL, Scopus, and Psych INFO. Inclusion criteria include: (a) full-text articles, (b) articles written in English, and (c) articles published between 1994 and 2014. A search of PubMed using the key word *advocacy* yielded 35,588 articles. When modified as *advocacy and community health nursing* and filtered by full text availability, articles written in English and published between 1994 and 2014, and restricted to humans, PubMed search yielded 61 articles; CINAHL Plus yielded 21 articles;

PsychInfo yielded 6 articles; and Scopus yielded 22 articles. Elimination of duplicates resulted in a total of 43 articles that were reviewed and used for this analysis.

## RESULTS

### Uses of [CHN] Advocacy

As specified by Walker and Avant (2010), as many uses of advocacy as I could find were identified both within and outside nursing. The following broader uses of advocacy that have implications for CHN were examined.

Advocacy is central to what nurses do in various underserved community settings. For example, in faith-based communities, nurses use advocacy to design and provide health promotion and disease prevention programs, and appropriate health services for the elderly population (McGinnis & Zoske, 2008). To reduce the risk of homelessness for women without permanent shelter, Speirs, Johnson, and Jirojwong (2013) reported that community health nurses use advocacy to develop structured education, support sessions, and therapeutic communities. They also noted that these interventions act to reduce psychological distress, improve self-esteem, and encourage the use of health care services. In an effort to support new immigrants in inner-city communities who often live in isolation, McElmurry, Park, and Busch (2003) observed that community health nursing advocates constitute a "bridge" between health programs and the community, and they promote cultural sensitivity (p. 277). In addition, they reported that community health advocates, particularly nurses, provide a range of services including health education and promotion, outreach through home visits, assessment of family needs for referrals to appropriate resources, and follow-up support.

The continued push for early patient discharge from hospitals requires that more complex treatments be provided in patients' homes and/or in ambulatory settings. Easing transition from acute care to home care requires much more than just medication management, but includes assessment of the caregiver burden, caregiver ability to cope, and follow-up appointments (Rooney, Markovitz, & Packard, 2011). This leads to a high demand for case managers. Although case managers strive to maintain a delicate balance between cost-containment for their employers and showing clients that they are on their side, they are always guided by the question, "What is in the best interest of the patient or family?" (Tahan, 2005, p. 136). Some of the advocacy strategies used by case managers were outlined by Tahan and include: care coordination, case conferencing, outcomes monitoring, communicating among team members, teaching, resolving disagreements, brokering services, obtaining consent, and providing clients and their families with emotional support and counseling. Also, community-based nurse case managers advocate for older women with breast cancer by helping to manage their coexisting medical conditions, providing education and support, assisting with activities of daily living, and helping to navigate through the health care system (Jennings-Sanders & Anderson, 2003).

In school settings, nurses and counselors use advocacy principles to promote and protect the health and safety of students, and to improve educational outcomes. The marked achievement gap, social inequities, economic- and politically based problems that are associated with race, ethnicity, and poverty prompted social justice advocacy among school counselors (Bemak & Chung, 2005). School counselors use the American Counseling Association's advocacy competencies as

a framework to promote access and equity for all students (Ratts, Dekruyf, & Chen-Hayes, 2007). Furthermore, school nurses work to bring change to the schools and to safeguard the health of children and the public (Kosiorowski, 2014). In discussing body image problems and their relationship to emotional, social, and physical health among college students, Rasberry (2008) noted that the use of advocacy through health education and behavior change interventions offers an excellent avenue for both treatment and prevention.

Forensic pathologists use advocacy to prevent child abuse and to protect victims who are unable to speak for themselves. Such forensic work involves providing the court with objective and medicalized testimony about a particular death (Kramer, 2006). It was supported by John Caffey's classic report on whiplash shaken infant syndrome (Caffey, 1974), which helped to establish the social and political value of forensic science to child maltreatment prevention movement (Kramer, 2005). Although forensic evidence has been challenged in court, such advocacy work is part of a broader, long-standing public health and safety mandate to "speak for the dead to protect the living" (Kramer, 2006, p. 803–804)

The high incidence of domestic violence in military families prompted the United States military to use advocacy programs to support and help families to overcome the effects of violence. The Department of Defense utilizes the family advocacy program to address child maltreatment and domestic abuse (US Department of Defense, 2011). Through their mandatory and nonmandatory reporting systems, the Navy helps families and victims to seek, and obtain, behavioral health care and victim advocacy services (Military One Source, 2014). The Air Force builds healthy communities through implementing programs designed for the prevention and treatment of child, spouse, and unmarried intimate partner maltreatment (30th Space Wing Instruction 40-301, 2014).

Nurses and numerous advocacy organizations and groups use advocacy to influence public health policy within local, state, and national legislative environments. For example, in coordination with its members, the American Public Health Association (APHA) collaborates with key decision-makers to shape public policies that address public health concerns such as access to care, food safety, hunger and nutrition, environmental health issues, disease control, international health, and tobacco control (APHA, 2014). Other specific examples of advocacy-driven public health policies include: (1) smoke-free work places, restaurants, and bars (American Nonsmokers' Rights Foundation, 2014; Nagelhout et al., 2014); (2) tobacco retail display ban—a point-of-sale initiative to reduce youth exposure to tobacco product marketing (Curry, Schmitt, & Juster, 2014); (3) the National Institute for Occupational Safety and Health guidelines in Washington State that protect health care workers from dangers of hazardous drugs (Eisenberg, 2012); and (4) restaurant menu labeling in King County Washington State that requires chain restaurants with 15 or more locations nationwide to provide calorie, saturated fat, carbohydrate, and sodium information to customers (Johnson, Payne, McNeese, & Allen, 2012). These public health issues and policies directly impact the health of communities.

## Defining Attributes

According to Walker and Avant (2010), the defining attributes of a concept constitute the heart of concept analysis and highlight a cluster of attributes that are most frequently associated with the concept. In other words, these are characteristics that occur over and over again throughout the

literature when CHN advocacy is described. The whole point of identifying defining attributes is to determine what counts as an "unequivocal" example (Paley, 1996, p. 574) of advocacy in CHN. The following attributes were determined by identifying the features that emerged repeatedly in the analysis of the literature.

1. Coordinating care and collaborating with clients and other stakeholders,
2. Promoting and protecting health and safety,
3. Providing support and assistance for access to health resources and social services,
4. Speaking up/for, and working on behalf of clients through the care continuum, and
5. Engaging in, and pushing for legislative actions to effect change.

These defining attributes encompass CHN at individual, family, community, and systems' levels. One of the marked attributes of CHN advocacy that emerged from the literature is *care coordination and collaboration with clients and stakeholders.* Inherent in political advocacy is the art of collaboration—a mutually beneficial relationship entered into by two or more individuals or groups to achieve common goals (Kosiorowski, 2014). Several definitions and uses of advocacy in the context of CHN revolve around the responsibility of the nurse to work closely with other health professionals to ensure that appropriate health care is available to the community when and if needed (Bollard, 2009; Chafey et al.,1998; Hagan & Donovan, 2012; R. Hanks, 2012; O'Connor & Kelly, 2005; Staines, 2009; Tahan, 2005). Other aspects of this attribute include the need to build a trusting partnership (McCorkle et al., 2011) and therapeutic relationship and communication between the nurse and the clients (R. Hanks, 2012). Care transitions from acute care settings to communities require a significant level of care coordination, interdisciplinary collaboration, and education of clients and care givers (Rooney et al., 2011).

The second attribute that emerged from the analysis is that CHN advocacy demands that the nurse *promote and protect the health and safety* of community members (Kosiorowski, 2014; Kramer, 2006; McGinnis & Zoske, 2008; Nelson, Allen, & Cox, 2005). Health promotion through education (a) helps communities to develop skills and knowledge that support changes in lifestyle and health behavior and (b) provides communities with tools to prevent disease and injury (Jennings-Sanders & Anderson, 2003; Speirs et al., 2013).

*Supporting and assisting community members to access health care resources and social services* is another characteristic of CHN advocacy. This attribute is most evident among vulnerable populations such as the homeless (Speirs et al., 2013), students (Ratts et al., 2007), and military families (Military One Source, 2014). Also, immigrant families need assistance and support to access health programs and resources (McElmurry et al., 2003) as well as the elderly (McGinnis & Zoske, 2008) and those living with chronic conditions such as cancer (Hagan & Donovan, 2012; Jennings-Sanders & Anderson, 2003). Within these communities, the nurse is the most important resource that connects clients to other systems level resources.

A clear and distinctive attribute of nursing advocacy in communities involve *speaking up/for, and working on behalf of clients* who cannot speak up for themselves, such as in cases of child abuse and injury (Kramer, 2006). This attribute has also been described by many scholars in different ways such as arguing (Ingram et al., 2008), intervening (Chafey et L., 1998), pleading (Allender et al., 2010), moderating (O'Connor & Kelly, 2005), and acting (Bu & Jezewski, 2007) on behalf of patients. This attribute also highlights clients' vulnerabilities as a key under-current for advocacy in communities.

*Engaging in, and pushing for legislative actions to effect change* is a distinctive attribute of CHN advocacy that threads throughout the literature. This involves taking a position on an issue, and initiating actions in a deliberate attempt to influence private and public policy choices (Labonte, 1994). Examples of advocacy work that resulted in health policy changes include previously highlighted smoke-free work places, restaurants and bars legislation (Curry et al., 2014; Nagelhout et al., 2014), health care worker protection from dangers of harzadous drugs (Eisenberg, 2012); and restaurant menu labeling (Johnson et al., 2012). CHN advocacy is important for the implementation and sustainability of legislation that impacts community health.

## Model Case

Walker and Avant (2010) noted that a model case is an example of the use of the concept that demonstrates all the defining attributes. It is one in which the analyst can say, "Well, if that isn't an example of it, then nothing is" (Wilson, 1963, p. 28).

A model case can be found in the Child Passenger Safety Advocacy in Washington State. This advocacy program especially focused on booster seat use in children between 4 and 8 years old, or until they reach the minimum height requirement of 4 feet 9 inches. The Seattle Children's Hospital worked with the Harborview Injury Prevention and Research Center, the Washington Traffic Safety Commission and the Washington State Safety Restraint Coalition to form the Washington State Booster Seat Coalition in 1999 (*coordination and collaboration*; Seattle Children's Hospital, 2014). The child safety advocacy program also involved a key stakeholder—the mother of Anton Skeen (a 4-year-old child who died in a car crash) whose testimony spurred a bipartisan state legislative effort (*speaking up and working on behalf of clients, and pushing for legislative change*). In 2000, the state legislature passed the very first booster seat law in the country—the Anton Skeen Act. The law (RCW 46.61.687), revised in 2007 is one of the strongest child restraint laws in the nation.

As part of this advocacy program, Seattle Children's Hospital holds quarterly community car seat checks that are open to the public. In addition, the hospital offers an infant car seat class for expecting parents through their Community Programs Department. These health promotion and child safety education opportunities for community members are offered by certified child passenger safety experts including nurses. In addition, Community Outreach Nurses educate and reinforce the correct use of car seats and booster seats for parents discharged from the hospital (*promoting and protecting health and safety*). Through the support of Allstate Foundation, Seattle Children's also provides low-cost booster and car seats to hospitalized patients and patients that visit the Emergency Department (Seattle Children's Hospital, 2014; *providing support and assistance for access*). This model case based on the Seattle Children's Hospital community programs has author additions to make the role of the community health nurse evident.

## Contrary Case

Contrary cases are clear examples of what the concept is not (Walker & Avant, 2010). I constructed this contrary case:

After conducting a community health needs assessment (CHNA) in a county with mostly low-income and immigrant communities, a CHNA Task Force was formed to review the data and

recommend strategies to address the health needs of the community. The Task Force identified priority health needs that include improved access to healthy foods and physical activity, among others. The county charged the Health Department with leading the efforts to work with the communities to design effective programs that will support the citizens to live healthier and prevent chronic illnesses. In response, the Health Department created small posters that urged people to eat healthy and exercise. These posters were posted at the Health Department's web site.

This is an instance of what CHN advocacy is not. There were no attempts to coordinate, collaborate, and engage with the community members, relevant stakeholders, and professionals to share knowledge and information, plan, implement effective campaigns, and advance policies through legislative actions. There was no support and assistance provided to the communities to help them to access information and resources that could promote their health and prevent diseases. Posting information on the Health Department's web site is not ideal for health-promotion activities for this county's population.

## Empirical Referents

The empirical referents are classes or categories of actual phenomena that, by their existence or presence, demonstrate the occurrence of the concept (Walker & Avant, 2010). Empirical referents are used to measure the defining attributes and therefore provide the nurse with clear observable evidence with which to demonstrate or determine the occurrence or presence of advocacy in the community. These include:

1. Active engagement with clients and decision makers (Eisenberg, 2012; Johnson et al., 2012; Maryland & Gonzalez, 2012; Speirs et al., 2013),
2. Education or information sharing sessions about issues to ensure that everyone involved is well informed (Kohnke, 1982; Rasberry, 2008), and
3. Intervening acts such as (a) providing guidance and counseling (Hagan & Donovan, 2012; Ratts et al., 2007; Tahan, 2005); (b) referring clients to appropriate resources (McElmurry et al., 2003); and (c) assessing problems, analyzing the impacts of the health issues on health, implementing specific programs, evaluating program impacts and outcomes, and pushing for change (Jennings-Sanders & Anderson, 2003; Kramer, 2005; Maryland & Gonzalez, 2012; Military One Source, 2014; Nagelhout et al., 2014).

The model case of Child Passenger Safety Advocacy program presented earlier also illustrates some of the empirical referents for CHN advocacy that are observable and measurable. For example; key stakeholders and decision makers actively worked together and shared information to help pass the Booster Seat Law. Testimonies were provided. Conducting infant car seat classes, car seat safety checks, and counseling about proper use of booster and car seats, in addition to availability of low cost car seats for parents constitute examples of intervening acts.

## Antecedents

The antecedents of advocacy in CHN are those events or incidents that must occur or be in place prior to the occurrence of the concept (Walker & Avant, 2010). Important triggers for advocacy include evidence of vulnerability, lack of voice or being less able to present needs, unaddressed

health needs, and lack of access to resources. These precursors of advocacy are evident in populations such as older women with breast cancer (Jennings-Sanders & Anderson, 2003), pregnant incarcerated women (Ferszt, 2011), chronically ill home care patients (Halamandaris, 2009), and refugee children (Woodland, Burgner, Paxton, & Zwi, 2010).

In addition, opposition to change could drive advocacy because all health issues are not equally important to all community constituents. Some issues will be favored by some constituents and not by others. The *raison d'être* of advocacy is, therefore, to persuade people and organizations to switch their views or policies to effect change (Gould et al., 2012). For nurses to engage in advocacy in community health, they must:

1. Care about an issue or issues of interest;
2. Possess a degree of knowledge or information regarding the issue and the community;
3. Have public health core competency skills in areas of needs assessment, communication, cultural understanding, and leadership and health systems thinking; and
4. Build a strong working relationship with clients.

Stokowski, McDonald, and Lovejoy (2010) recommended that nurses should consider issues that they can respond most passionately to and become educated about those issues. They also need a variety of competencies such as the American Counseling Association's advocacy competency framework (Ratts et al., 2007), and the public health core competencies developed by the Council on Linkages Between Academia and Public Health Practice (2014). In addition, nurses need to have knowledge and skills on "how decisions are made and who has the power to make them" as well as the "media, framing issues, and lobbying" (Gould et al., 2012, p. 169). A working and trusting relationship with clients is a prerequisite for effective advocacy (Bell & Buelow, 2014).

### Consequences

According to Walker and Avant (2010), the consequences of a concept are the outcomes of the concept. They are events or incidents that follow or occur as a result of advocacy in CHN practice. The consequences include improved access to health and social services (McElmurry et al., 2003; McGinnis & Zoske, 2008); equity and social justice (Bemak & Chung, 2005; Labonte, 1994; Pauly, MacKinnon & Varcoe, 2009; Ratts et al., 2007); client and community empowerment (Bell & Buelow, 2014; Labonte, 1994; Vaartio, Leini-Kilpi, Salantera, & Suominen, 2006); and health and social reform/change (Abood, 2007; Bemak & Chung, 2005). Specific consequences of advocacy in CHN practice may vary depending on the type of communities, and their specific needs. A summary of the antecedents, defining attributes, empirical referents and consequences of the concept of CHN advocacy is presented in Figure 1.

## DEFINITION OF CHN ADVOCACY

By clarifying and identifying the defining attributes, empirical referents, antecedents, and consequences, I proposed a synthesized operational definition of CHN advocacy as an act of promoting and protecting the health of communities by collaborating with relevant stakeholders, facilitating access to health and social services, and actively engaging key decision makers to support and enact policies to improve community health outcomes.

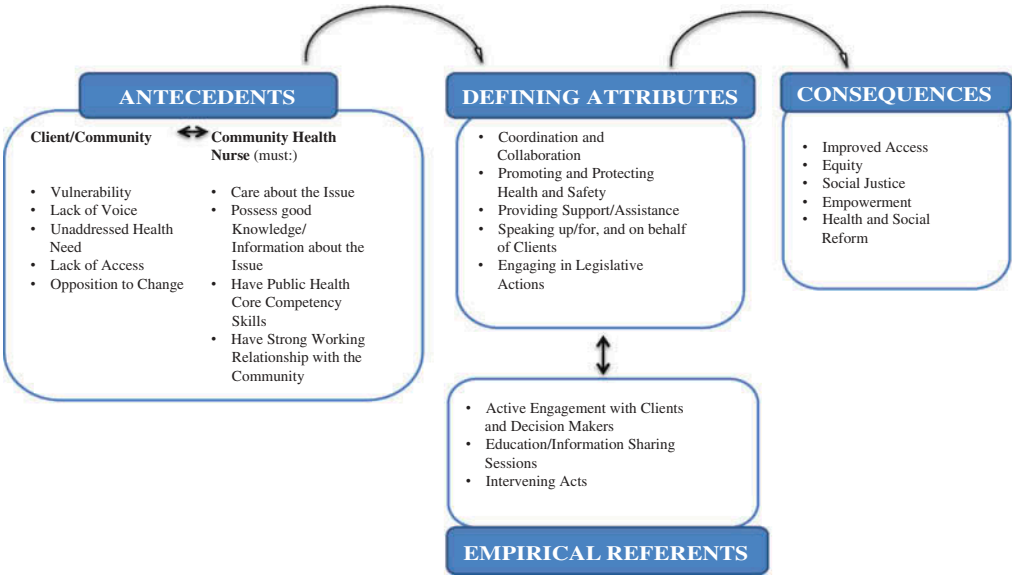


FIGURE 1 Antecedents, Defining Attributes, Empirical Referents, and Consequences of Community Health Nursing Advocacy.

## DISCUSSION

Every encounter a nurse has with a client in a community setting presents opportunities for advocacy. CHN advocacy is an intentional act. Although some scholars argue that advocacy is part of nurses' professional duties and responsibilities (Bird, 2004; Nault & Sincox, 2014), Vaartio et al. (2006) reported that nursing advocacy goes beyond a professional task. This analysis shows that it is not enough for the community health nurse to secure mental health services or temporary housing for a homeless person living at the storefront, for example. To be effective, advocacy, as an intervention, must involve addressing the root causes of homelessness through policy change by involving relevant decision makers. Nurses therefore use advocacy to influence legislative action with the goal of improving the public's health (Maryland & Gonzalez, 2012).

Collaboration with community members, other professionals and key decision makers is fundamental to CHN advocacy. Expert power provides nurses with considerable credibility to speak out on health care issues (Abood, 2007). Nurses' engagement in legislative activities is an important attribute of CHN advocacy. As the largest single group of health professionals (3.1 million), registered nurses not only have the ability to be a force by sheer numbers, but policy makers also rely upon nurses' expertise as they have one of the better views of the health care challenges facing providers and clients, and they understand the health care system (Abood, 2007; American Nurses Association, 2014). Because issues that affect nursing practice go through the legislative process, nurses must be at that table (Nault & Sincox, 2014). Gould et al. (2012) asserted that if health professionals do not commit to advocacy for health, they are squandering opportunities to improve living conditions and to address the broader determinants of health.

For professional nurses to take the lead in improving community health outcomes, they must develop advocacy skills inherent in the future scope of nursing (National League for Nursing, 2014). Although the American Association of Colleges of Nursing's [AACN] Essentials of Baccalaureate Nursing Education (AACN, 2008) and Essentials of Master's Education in Nursing (AACN, 2011) emphasize policy and advocacy, most nursing curricula are yet to incorporate adequate opportunities for active advocacy skills development. There is also a substantial gap in public health school curriculum regarding advocacy (Hines & Jernigan, 2012). To fill the skills gap, specific course content about the political process should be integrated across nursing programs to cultivate political interest (Vandenhouten et al., 2011). Furthermore, faculty's skills development in advocacy should be supported (Radius, Galer-Unti, & Tappe, 2009).

This analysis identifies CHN advocacy as a series of actions—characterized by defining attributes that could lead to improved health outcomes for community members. Allender et al. (2010) described advocacy as a process, one that includes identifying an issue, collecting information, identifying who can be influenced/who can make the decision sought, building support, and taking action. Vaartio et al. (2006) also noted that advocacy is not a single event, but a process of analyzing, counseling, responding, shielding and whistle-blowing activities in nursing practice. The existence of necessary conditions for advocacy (antecedents) and appropriate advocacy actions in the community should, therefore, lead to positive community health outcomes or some improvements over the status quo.

Not all advocacy activities in community health result in improved access to health care services, equity, social justice, empowerment, or policy change. There are challenges to the advocacy process, including poor knowledge of the legislative process (Nault & Sincox, 2014), conflict with medical colleagues and employers (Gould et al., 2012; R. G. Hanks, 2007; Mardell, 1996), lack of time to interact with important stakeholders, and nurses' lack of education and adequate knowledge of the issues (Gould et al., 2012; R. G. Hanks, 2007). In addition, the bureaucratic nature of the healthcare system, delays in the legislative process, and navigating through multiple community stakeholders with layered interests and agenda often stall advocacy efforts or move advocacy outcomes in different directions (Abood, 2007; Ezeonwu, 2014; Gould et al., 2012). A future scholarly inquiry that examines the negative or undesired outcomes of CHN advocacy and how nurses and/or community members respond to them is recommended.

## LIMITATIONS

The Walker and Avant's (2010) concept analysis technique provides a structured and rigorous way of dissecting a concept to clarify its meaning. There are, however, limitations in the procedures. There are no specific guidelines for the different elements of the analysis. For example, although as many uses of advocacy as possible were identified which are linked to community health, there were no recommended strategies to identify the uses of the concept. Because advocacy is a common concept that has crossed many professional boundaries, it is difficult to know what to include and what not to include while maintaining creativity. Furthermore, the lack of specific guidelines results in blurred lines in identifying the defining attributes, antecedents, and consequences leading to multiple refinements to prevent overlaps or contradictions.

## CONCLUSION

This analysis defines CHN advocacy as an act of promoting and protecting the health of communities by collaborating with relevant stakeholders, facilitating access to health and social services, and actively engaging key decision makers to support and enact policies to improve community health outcomes**.** As an action-packed complex process that aims to improve health outcomes of vulnerable populations, effort is needed to influence legislative changes. This analysis is grounded in theory and provides nurse clinicians, educators, and researchers with a framework to guide their advocacy work in communities. It also provides a template that could be used to challenge or critique advocacy within community health nursing practice and research.

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