CAMPUS & COMMUNITY Civic Health Initiative

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Defining Civic Health: Project Report

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Summary

This report describes the process and outcomes of the "Defining Civic Health" project, which used a modified Delphi process to engage nearly 150 stakeholders in a deliberative, consensus-building process to create definitions of *civic health.* This process will help inform the future work of the National Conference on Citizenship (NCoC), the American Democracy Project (ADP), and potentially other organizations. The resulting definition from the consensus process is as follows:

Civic health is the measure of the civic, social, and political strength of a community.

- Civic strength is characterized by the level of individual engagement and the community's capacity to work together to resolve collective problems. Specific indicators of this include volunteerism and service, group participation, charitable giving, and collective action.
- Social strength captures the social ties, networks, levels of trust, and exchange of knowledge and ideas in a community. Specific indicators of this include trust in neighbors, confidence in institutions, access to and use of information, and interactions among family, friends, neighbors, and groups.
- Political strength gauges the extent of interaction between citizens and government. Specific indicators of this include voter registration and turnout, interactions between citizens and elected officials, expression of political opinion, and engagement in public dialogue, processes, and decision making.

These dimensions of civic health are fundamentally interwoven and overlapping.

This definition will be disseminated over the next month and discussed among the participants in the Campus & Community Civic Health Initiative in June.

The following report provides a complete description of the project, process, and outcomes.

American Democracy Project
American Association of State Colleges and Universities

NCoC
National Conference on Citizenship
Chartered by Congress

Background

In 2006, NCoC and partners began *America's Civic Health Index* in response to the lack of data available about the civic vitality of U.S. communities. At that time, NCoC convened a working group of leading thinkers who developed the term *civic health* to capture a set of indicators that include voting and volunteering, social connectedness, group participation, trust and confidence, and more. NCoC now conducts an annual national civic health assessment, "Civic Life in America," in partnership with the Corporation for National and Community Service and the U.S. Census Bureau, and works in 30 communities nationwide.

Building upon this foundation, NCoC and ADP launched the Campus & Community Civic Health Initiative, engaging 25 campuses in a two-year initiative to measure and improve the civic health of their campuses and local communities. While *civic health* is understood broadly to capture the many ways in which citizens are engaged in their neighborhoods, communities, and democracy, it can mean different things to different people. The "Defining Civic Health" project was launched by the Campus & Community Health Initiative to reach a consensus on a concise and clear definition for this multi-faceted concept.

The project was led for NCoC and ADP by Professor Sherril Gelmon of Portland State University and Community-Campus Partnerships for Health (CCPH), working with Laura Kreger, a research assistant at Portland State. Project oversight was provided by Jennifer Domagal-Goldman, National Manager of ADP for the American Association of State Colleges and Universities (AASCU), and Kristi Tate**,** Director of Community Strategies for NCoC.

Project Process

The definitions of *civic health* for this project were generated through the use of a multiple-iteration, modified Delphi design that included three sequential surveys. The Delphi technique is a method for structuring and facilitating a group communication process to address a complex issue. The essence of the Delphi technique is "structured, indirect, iterative interaction among experts with centralized control, tabulation, and feedback of information and judgments" (Averch, 2004, p. 300). This structured technique is particularly useful when the issue does not lend itself to precise analytic techniques but is better addressed by pooling expert opinion on complex issues. The technique is based on the assumption that "many heads are better than one" and that a group deliberation will be more reliable than the advice of a single expert.

Typically, the Delphi process involves some sort of survey administration in three successive iterations to aggregate the views of a group of experts, allowing them to remain anonymous while preventing domination by particular individuals who might otherwise be overly influential in a group discussion. Each successive survey gives participants feedback on the entire group's responses to previous iterations of the study. This allows respondents to consider their own position, view the collective responses of others, and then either change their responses, maintain their previously held positions, or move toward group consensus.

To gather expert opinion on a definition of *civic health*, we used a conventional three-iteration Delphi design that included sequential surveys (Linstone & Turoff, 1975; Stritter et al., 1994). The consensus-building exercise began with an email invitation from ADP and NCoC leaders to an identified stakeholder group, advising them of the process. The list of invited participants (partners from NCoC, ADP, CCCHI, CCPH, and other key informants) included individuals in administrative, faculty, policy, and other roles who all shared a common interest in this

work. They were provided with background information and were invited to convene organizational and/or campus-based conversations about defining civic health. The campuses participating in the Campus & Community Civic Health Initiative were encouraged to facilitate discussions among members of their civic health teams in order to participate. The invited stakeholders were also invited to recommend other colleagues to participate, which added to the list of invitees. The cut-off point for invitations was the end of the first iteration of the survey.

The process involved three iterations. Each survey was conducted online and was prompted by an individual email to allow participants to respond quickly and easily. The purpose of the first iteration was to generate a list of independent definitions of *civic health*; the invitation was sent to 136 individuals. This invitation included a survey link that invited participants to consider the term *civic health* and write their own definition, limited to 400 characters. If participants used a published definition, they were asked to provide the citation. Individuals were given approximately two weeks to respond, and were sent a reminder email the day before the survey closed. They were asked to not post the invitation to public listservs to maintain the integrity of the participant list and limit it to individuals connected to this work.

Forty-two (42) responses were received in the first iteration. These responses were reviewed to remove any redundancy (of which there was none significant enough to warrant combining definitions) and were minimally edited for format consistency. One response was split into two definitions given the extent of content offered, providing a total of 43 unique definitions. These responses were used to create the second survey.

The second iteration was sent to 137 individuals (all individuals from the first iteration whether or not they completed the survey, plus one additional individual referred to us during the first iteration). Individuals were invited to review each definition and consider how well that definition described what they believe *civic health* means. Participants were asked to rate each definition as stated using a 5-point Likert scale from "strongly dissatisfied" to "strongly satisfied." Participants were given two weeks to complete this iteration and were sent a reminder along with an extension of two days to attempt to collect more responses.

Sixty-three (63) responses were received to the second iteration. Based on participant answers of "very dissatisfied" (1 point assigned) through "very satisfied" (5 points assigned), mean scores were calculated for each definition. The responses to the second survey were configured into a third survey that asked respondents to reconsider their ratings based on the group response, and rank their top ten definitions. The third iteration was sent to the 63 individuals who participated in the second iteration. In all communications, it was made clear that only those responding to the second iteration would receive the invitation to the third and final iteration – this encouraged people to respond to the second iteration, but it also ensured that only those who had participated and engaged in the process were involved in the final ranking in the third iteration.

In this third and final iteration, the definitions generated in the first iteration were presented again, along with the mean scores calculated from the responses in the second iteration. The definitions were presented in their original order (not from highest to lowest mean scores). Participants were asked to review each definition, consider the average score, and rank their top 10 choices in terms of their preference for adopting the definition. This survey used a drag-and-drop format in which participants were asked to drag their top 10 choices into the top 10 slots (creating movement, which allowed quick visual feedback of the placement of the various

definitions). They were asked to consider the suitability and clarity of the definitions for their unique professional purposes, whatever their organization. Individuals were given two weeks to respond and were sent a reminder three days before the survey closed.

Forty-six (46) responses were received to the third iteration. Scores were assigned to each participant's top 10 definitions, with 10 points assigned to each #1 ranking, 9 points assigned to each #2 ranking, etc. These scores were compiled and used to calculate a mean score for each of the 43 definitions. The third iteration was critical in that it allowed respondents to revisit the rankings in the context of the group's scoring to identify the most relevant definitions.

Each survey was sent with an introductory email using Tailored Design method techniques to obtain maximum survey response rates (Dillman, 2000). All potential respondents received the first two surveys (N=137); only those responding to the second survey received the third and final survey (N=63).

Results

The results represent three distinct interest groups: the campuses participating in the Campus & Community Civic Health Initiative; the NCoC key stakeholder group made up of Civic Health Index partners; and a third group of other stakeholders from CCPH and other organizations. A factor affecting the interpretation of results is whether one group participated more than others. As can be seen in Table 1, for each group, the percent responding within that group increased in each round. In all three groups, there were more respondents in round two than in round one; since round three was only sent to the round two respondents, the percentage response rate increased dramatically in round three.

Table 1: Summary of Individual Responses by Iteration

	ADP Group			NCoC Group			Other Invitations			Total		
	Invited	Responded		Invited	Responded		Invited	Responded		Invited	Responded	
	N	N	%	N	N	%	N	N	%	N	N	%
Iteration 1	72	24	33%	37	12	32%	27	6	22%	136	42	31%
Iteration 2	72	37	51%	37	18	49%	28	11	39%	137	66	48%
Iteration 3	35	23	66%	18	15	83%	10	5	50%	63	43	68%

The 25 campuses participating in the CCCHI were invited to identify individuals to participate, or to send a collective response by campus. The responses in Table 1 for the ADP Group include individual respondents from these campuses and other ADP stakeholders. At least one respondent from twenty-two (22) of the 25 campuses participating in the CCCHI initiative participated in at least one iteration (88% of the campuses). Over half of the campuses contributed to the first iteration, and over three quarters of the campuses contributed to the second iteration. The responses of those invited to the third iteration represent responses from three quarters of the participating campuses.

This complete consensus process created a list of 43 unique definitions of *civic health* that were scored and ranked by an interested stakeholder group in terms of their preference for adopting the definitions for their work. While a few participants included citation information for general concepts, all definitions were determined to be original.

Six definitions stood out based upon receiving the highest rankings in the third iteration and the highest percentage of respondents who ranked these definitions among their top three choices. These are presented in Table 2 below.

Table 2: Six Top-Ranked Definitions

Definition	Iteration 3: Mean Score (max 10)	% Respondents Ranking Definition as #1, #2, or #3
Civic health is a measure of the civic, social, and political strength of a community. Civic strength is characterized by the level of community involvement and capacity of a community to work together to resolve collective problems. Social strength captures the social ties, networks, level of trust, and shared understanding in a community. Political strength gauges the extent of citizens' involvement with government.	5.46	50.00
Civic health is the collective of indicators that measure a wide range of civic relationships, processes, pathways, and practices through which ordinary individuals participate in various aspects of public life. Indicators of civic health include social connectedness, civic engagement, group participation, donating, political participation, and access to and use of information towards public good.	4.63	23.91
Civic health is the characteristic of a community defined by the breadth and depth of involvement by its residents in the processes and activities by which the community is governed and by which residents engage in collective and individual action for the betterment of the community.	4.52	32.61
Civic health refers to the quality and strength of connections between individuals and groups across many layers of community life, and includes measurements of participation, knowledge, and trust among citizens.	4.17	30.43
Civic health includes a continuum of behaviors that describe how citizens relate to government, community, and one another. The behaviors range from such traditional actions as voting (civic engagement) and volunteering (community involvement) to actions and attitudes (e.g., trust in neighbors) that measure the social cohesion embedded in our personal relationships.	4.17	30.43
Civic health is the measure of commitment to the long-term well-being of our democracy, as recognized through meaningful collective action; quality dialogue surrounding civic issues; citizen engagement with policy setting and decision making; programming and resources to mitigate persistent inequalities; vibrant public education; public spaces to express dissent; and inclusion of relevant stakeholders.	3.52	17.39

An analysis of these six definitions and the related scores and rankings suggested that no one definition included all of the key elements participants were seeking in a definition. Top-ranked definitions identified *civic health* as a multi-faceted concept describing the relationships between and among individuals, groups, and government. No single level (individual, group, or government) is given responsibility or ownership, as this is about collective action. *Civic health* includes actions, knowledge, and attitudes with the goal of solving collective problems.

Common elements of these top-ranked definitions include the following examples:

- Group effort ("community involvement," "group participation," "collective action")
- Goal of improving the community ("resolve collective problems," "towards public good," "betterment of the community," "mitigate persistent inequalities," "commitment to the long-term well-being of our democracy")
- Social strength ("social connectedness," "social ties," "social networks," "social cohesion," "shared understanding")
- Civic engagement ("relate to government," "involvement with government," "political participation")
- Both individual and collective ("collective and individual action," "connections to both individuals and groups," "relate to . . . community and one another")
- Trust ("level of trust . . . in a community," "trust among citizens," "trust in neighbors")
- Knowledge ("access to and use of information," "includes measurements of . . . knowledge," "vibrant public education")

Consensus Definition

The project working group considered these top-ranked definitions and worked together to create a single definition that incorporates nearly all of the elements that emerged from the consensus process within a relatively brief and coherent set of statements. The definition that emerged is the following:

Civic health is the measure of the civic, social, and political strength of a community.

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These dimensions of civic health are fundamentally interwoven and overlapping.

Limitations

There are both strengths and limitations to the methodology used here. The use of a modified Delphi technique infused the endeavor with the expertise of a large group of experts. This might have been enhanced if more individuals had been invited to participate; however, the "closed" nature of the invitation list assured that everyone invited to participate was familiar with the concept of civic health.

As is always a weakness in the Delphi process, it is difficult to synthesize the many responses initially generated in the first iteration without losing some of the original meaning or intent. To avoid this, the project leaders left definitions largely intact as submitted, even though some responses contained multiple constructs, redundancies, or unclear statements. The potential of a

process like this to create the best consensus definition is constrained by the quality of the original submitted definitions.

Very few participants expressed difficulty with completing the iterations, suggesting that the format did not limit participation. Many participants expressed their satisfaction with the relevant ease of the survey format, and commented in particular on the interactive nature of the drag-and-drop format in the third and final iteration.

For this project, the Delphi process proved to be a cost-effective, time-efficient, and engaging process to stimulate creative thinking and move relatively quickly through an idea-generation and distillation process, resulting in the definition(s) presented.

Next Steps

These results are now being shared via this document with the participants and key stakeholders. You are invited to offer your comments on the final definition by email to Kristi Tate at NCoC (ktate@ncoc.net) or Jennifer Domagal-Goldman at ADP (domagalj@aascu.org). Please remember that the intent of this exercise is to build consensus, so avoid crafting a new definition in offering comments at this point. The results will also be discussed by the participants in the Campus & Community Civic Health Initiative at their meeting in June. From these discussions and feedback, the project leaders will determine how to use these definitions to guide future work.

For further information, contact Prof. Sherril Gelmon at gelmons@pdx.edu.

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