RESOURCE GUIDE TO CONCEPTS AND METHODS FOR COMMUNITY-BASED AND COLLABORATIVE PROBLEM SOLVING

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The Women's and Children's Health Policy Center (WCHPC) at the Johns Hopkins University was established in 1991 to address current policy issues found in national legislative initiatives and evolving health systems reforms impacting on the health of women, children, and adolescents. The mission of the center – which operated during its first five years as the Child and Adolescent Health Policy Center – is to draw upon the science base of the university setting to conduct and disseminate research to inform maternal and child health policies and programs, and the practice of maternal and child health nationally. Projects are conducted to provide information and analytical tools useful to public and private sector MCH professionals and to elected officials and other policymakers.

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Contents

Introduction

The last two decades have seen a sort of convergent evolution of concepts related to community-based problem solving and the conditions necessary for community health and well-being. Researchers of different disciplines and orientations delineate constructs like community capacity, community competence, community empowerment, and community readiness. All attempt to capture at least some of the characteristics and resources that enable communities to participate successfully in problem solving. Coupled with these ideas are others related to community coalitions and other collaborative strategies to promote community-driven change.

Underneath the proliferation of terms surrounding community-based initiatives and community collaboratives are three basic principles: 1) a population, rather than individual, approach to health promotion, 2) acknowledgement of the effect of social environment on individual and population health status, and 3) a recognition of the importance of changing health and related service systems in order to impact health status.[1] Also central to most of these concepts is an assets-based approach to understanding communities, one cognizant both of the resources and skills a community brings to bear in addressing common needs and of the importance of enhancing the community's ability to mobilize those assets.[2]

This resource guide brings together documents that contribute to the knowledge base about community resources promoting effective problem solving and health systems change, with a special emphasis on issues pertaining to the measurement of key constructs. The literature consolidated here provides guidance on assessing the community context to gauge: 1) how community context will affect the development and success of initiatives, and, conversely, 2) how community-based systems initiatives may influence community capacity. To understand the potential effect of community context on a program, for example, a pre-implementation assessment of community readiness for intervention might provide important information for use in targeting resources and activities. Gauging the effects of collaborative/interagency initiatives on the community is a more complex endeavor; the literature as of yet offers little guidance for linking specific collaborative initiatives to population-based outcomes. This document summarizes recent progress in developing process and outcome measures for use in examining community collaboratives and documenting their impact.

This guide is organized into several sections. *Part One* introduces key concepts related to community-based program planning and evaluation, outlining the various ways different authors have elaborated these concepts. In *Part Two*, the sources included in this guide are matched to the concepts they explore for easy identification of resources of interest to the reader. An annotated bibliography of resources related to community-based and collaborative problem solving follows. This bibliography includes both references readily found in the research literature and "fugitive" documents that might not otherwise come to the reader's attention. *Part Three* consists of expanded summaries of selected resources from the annotated bibliography. The resources chosen for expanded summary stand out as seminal works on practice-oriented concepts and/or methodological tools. Finally, *Part Four* lists internet resources that can serve as jumping off points for explorations of a broad range of concepts and activities related to community-based problem solving.

Publications were selected for inclusion in this Resource Guide according to three criteria:

- Broadly applicable: Concepts and methods are not limited to use with specific kinds of initiatives (e.g., substance abuse prevention programs, community development initiatives).

- Practical: Includes explicit descriptions of constructs or of measurement methods that can be adapted for other, similar uses.

- Adding to the knowledge base: Contributes to a broader understanding of key concepts and/or how to measure them.

[1]Kreuter & Lezin, 1998.
[2]Goodman et al., 1998.

Publications that are *not* included in this resource book are those that serve primarily as "how to" guides, such as those that detail steps to building community coalitions or mobilizing/empowering community members without *also* contributing to or reviewing salient conceptual or methodological approaches. However, all of the websites listed in Part Four provide access to publications and other resources for technical assistance in community-building activities.

The Johns Hopkins University Women's and Children's Health Policy Center (WCHPC) compiled this literature while designing several studies currently underway. The Maternal and Child Health Bureau asked the WCHPC to develop this Resource Guide to make what has been learned by the faculty and staff of the Center more readily accessible to local and state maternal and child health professionals, whose work daily involves aspects of the principles, concepts, and activities reviewed in this document. As performance measurement issues continue to move to the forefront of public health practice, access to this material may become increasingly valuable to public health administrators and managers.

Key Concepts Related to Community-Based, Collaborative Problem-Solving

Concept	Definition	Author(s)	‡
	Defining and Involving the Community		
Community	Communities are "systems composed of individual members and sectors that have a variety of distinct characteristics and interrelationships." They can be defined by the characteristics of its people; geographic boundaries; shared values, interests, or history; or power dynamics.	CDC, 1998	
	The definition of a community should take into account "opportunity for interpersonal and networking interactions within the unit."	Hancock et al., 1997	
	Elements of community include: a sense of membership; common symbol systems; common values; reciprocal influence; common needs and a commitment to meeting them; and a shared history.	Israel et al., 1994	X
	Communities can be conceived of as geographic communities (e.g. residents of a geographically-defined neighborhood) or affinity communities (e.g. a community of providers, a religious group).	Kumpfer et al., 1993	
	"Community" refers to a multidimensional system which encompasses interactions across both horizontal and vertical levels and is characterized by people and organizations, actions, context, and consciousness (perceptions and cultural constructs). Community is variable and permeable, shaped and re-shaped continuously by changing actions and relationships.	Walter, 1997	
Community Involvement/ Participation	Community participation is defined as involvement in decision-making processes and implementation, as well as sharing the benefits of the program. Participation occurs along a continuum, from active involvement in all stages of the intervention, or "community development/organizing," to token or consultative involvement, or "community-based."	Hancock et al., 1997	
	Two models of community involvement: 1) The *service consortium model* focuses on involvement of local providers/professionals, with impact measured by access to services and quality, coordination, and utilization of services. 2) The *community empowerment model* focuses on participation of nonprofessional community members in the planning process via neighborhood-based groups, service-provision contracts with community-based organizations, employment of community members, and economic development initiatives.	Howell et al., 1998	X
	Community Resources for Collective Action		
Community Competence	In a competent community, "the various component parts of the community: 1) are able to collaborate effectively in identifying the problems and needs of the community; 2) can achieve a working consensus on goals and priorities; 3) can agree on ways and means to implement the agreed-upon goals; and 4) can collaborate effectively in the required actions."	Cottrell, 1976	
	The dimensions of community competence include: commitment, self-other awareness and clarity of situational definitions (accurate perceptions of divergent viewpoints), articulateness, communication, conflict containment and accommodation, participation, management of relations with the larger society, and machinery for facilitating participant interaction and decision making. Social support and leadership development have also been added in some conceptualizations.	Cottrell, 1976; Denham, Quinn, & Gamble, 1998; Eng & Parker, 1994; Goeppinger & Baglioni, 1985	X

Concept	Definition	Author(s)	‡
	"Community competence is the capacity of a community to assess and generate the conditions required to demand or execute change," the ability to "pull it together." Community competence can be described as "an individual-systems interaction, with 'systems' being human service organizations. Effective interaction is characterized by: 1) the match between the problem-solving preferences of an individual and the resources provided by a system, 2) informational-feedback between the two parties that allows for adjustment on either side, and 3) the availability of advocacy or participatory processes."	Eng & Parker, 1994	X
	Different definitions of community competence have in common "the notion that the parts of a community develop congruent perceptions of one another through social interaction and that congruent perceptions are necessary for the identification and resolution of community issues."	Goeppinger & Baglioni, 1985	X
	A competent community harnesses and enhances resources, particularly those indigenous to the community, and transfers power to the disenfranchised.	Iscoe, 1974	
	A competent community is skilled in problem solving and provides resources that aid the well-being of community members. Characteristics of a competent community include "collaboration for integration of services and decision-making, which is facilitated by knowledge of other agencies and services, and participation by citizens in the functioning of organizations."	Knight, Johnson, & Holbert, 1991	X
Community Empowerment	"Community-level empowerment (i.e., the capacity of communities to respond effectively to collective problems) occurs when both individuals and institutions have sufficient power to achieve substantially satisfactory outcomes."	CDC, 1998	
	"Community empowerment is both the process and outcome of *organized* community members gaining control over their lives." Community empowerment is commonly conceptualized as community participation, mobilization, and ownership.	Eisen, 1994	
	Community empowerment refers to "the process of gaining influence over conditions that matter to people who share neighborhoods, workplaces, experiences, or concerns."	Fawcett et al., 1995	
	Empowerment suggests "the ability of people to gain understanding and control over personal, social, economic, and political forces in order to take action to improve their life situations." Empowered communities are characterized by resource sharing, collective problem solving, influence on the larger social system, and the ability to obtain equitable resources.	Israel et al., 1994	X
Organizational Empowerment	Empowered and empowering organizations are characterized by: • democratic management; • individuals' control within the organization; • influence in the larger community; and • recognition of the "cross-cutting linkages among members."	Israel et al., 1994	X
	An *empowering* organization enhances the collective empowerment of its members, while an *empowered* organization is able to effectively influence institutions in its environment.	McMillan et al., 1995	

Concept	Definition	Author(s)	‡
Community Readiness	Community readiness can be described along a spectrum related to Roger's (1983) stages of diffusion of innovations and Prochaska's (1992) stages of psychological readiness: 1) community tolerance, 2) denial, 3) vague awareness, 4) preplanning, 5) preparation, 6) initiation, 7) institutionalization, 8) confirmation/expansion, and 9) professionalization.	Oetting et al., 1995	X
	Community readiness is an aggregate measure of residents' willingness to engage in collective problem-solving activities.	Peyrot & Smith, 1998	X
Social Capital	"Social capital is defined as the specific processes among people and organizations, working collaboratively in an atmosphere of trust, that lead to accomplishing a goal of *mutual social benefit*. The theory of social capital appears to be manifested by four constructs: trust, cooperation, civic engagement, and reciprocity."	Kreuter & Lezin, 1998	X
Community Capacity	Community capacity is reflected in the commitment, resources, and skills brought to bear on community problem solving and assets building.	The Aspen Institute, 1996	X
	"Community capacity is the currency that residents bring to the table when they are inspired (or threatened) by an issue that speaks directly to their collective well-being." Its elements include skills and knowledge, leadership, sense of efficacy, trusting relationships, and a culture of learning.	Easterling et al., 1998	X
	Community capacity can be conceived of as the characteristics affecting the community's ability to identify and solve problems and its cultivation and use of resources toward that end. Community capacity is a "potential state" corresponding to the "active state" of community competence – that is, competence is the effective use of capacity.	Goodman et al., 1998	X
	The dimensions of community capacity include: participation; leadership; skills; resources; social and interorganizational networks; sense of community; understanding of community history; community power; community values; and critical reflection.	Goodman et al., 1998	X
Institutionalization of Programs	A program is institutionalized when it becomes integral to and embedded within an organization or community. Institutionalization describes the "built-in-ness" of a program.	Goodman et al., 1993; McLeroy et al., 1994	
Mobilizing Community Resources			
Community Engagement	Community engagement is "the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being," often through partnerships or coalitions.	CDC, 1998	
Community Organizing	Community organizing is a process by which the problem-solving capacity of communities is enhanced.	CDC, 1998	
	Community organizing is another term for "community development," which involves a high level of community involvement in all aspects of intervention activities.	Hancock et al., 1997	
Community Action	Community action entails a lower level of community involvement than does community organizing, but includes some measure of community control over the implementation of interventions.	Hancock et al., 1997	
	Community action is characterized by "a collective rather than an individual approach to health, a social rather than a medical model of health and illness, a preventive rather than curative orientation to health problems, and the participation of community members in health care decisions."	Hancock et al., 1997	

Collaborative Problem Solving			
Community Coalitions	Coalitions are "interorganizational, cooperative and synergistic working alliances" which are distinguished from other group arrangements such as networks and consortia.	Butterfoss, Goodman, & Wandersman, 1993	
	Coalitions are issue-oriented, structured/formal, focused on external goals, made up of diverse members/organizations, and sustainable over the long term. Like other group arrangements, coalitions are characterized by unity and a shared purpose; unlike other group arrangements, members work on behalf of their own organizations as well as the coalition itself.	Butterfoss, Goodman, & Wandersman, 1993	
	Health promotion coalitions specifically are usually long-term and multi-faceted; aimed at complex and difficult problems; community-based *or* agency-dominated; and focused on planning and implementing prevention activities.	Butterfoss, Goodman, & Wandersman, 1993	
	Coalitions can be classified by membership (grassroots, professional, other coalitions or organizations, or a combination), reason for formation (funding opportunity, external threat), and functions (advocacy, information and resource sharing, integration of services).	Butterfoss, Goodman, & Wandersman, 1993	
	A community coalition is a formal alliance of diverse groups or agencies working toward a common goal and is often characterized by a focus on multiple factors, multiple levels of influence, and participation of community members. In a coalition, groups share resources to bring about changes that would not be possible working separately.	Florin, Mitchell, & Stevenson, 1993; Wandersman et al., 1996	
	Community health coalitions use two community development strategies: 1) social planning, a top-down approach with problem solving by professionals, or 2) locality development, involving citizen participation and building indigenous leadership capacity.	Francisco, Paine, & Fawcett, 1993	X
	Unlike consortia (see below), coalitions consist of "groups of varied organizations whose interests converge or overlap to varying degrees, but whose member organizations have separate agendas and interests of their own." The goals and missions of coalitions are more broad than those of consortia.	Kreuter & Lezin, 1998	X

Coalition Development	4-stage model of coalition development: 1) Formation 2) Implementation 3) Maintenance 4) Accomplishing goals/outcomes	Butterfoss, Goodman, & Wandersman, 1993	
	7-stage model of coalition development: 1) Initial mobilization 2) Establishing organizational structure 3) Building capacity for action 4) Planning for action 5) Implementation 6) Refinement 7) Institutionalization	Florin, Mitchell, & Stevenson, 1993	
	3-stage model of coalition development: 1) Formation: Building committees with broad representation, conducting needs assessment, and generating plans. 2) Implementation: Implementing, maintaining, and routinizing programs and plans. 3) Institutionalization: Continuation of coalition or adoption of programs and policies by other institutions after initial funding ends.	Wandersman et al., 1996	
Collaboratives/ Consortia	Collaborative problem solving involves four beliefs: 1) solutions must be acceptable to the community experiencing the problem, 2) enduring change is only possible with the involvement of the community experiencing the problem, 3) collaborative problem solving enhances community capacity and leadership, and 4) "sectorial approaches to complex development problems cannot mobilize the full range of resources required to effect sustainable change."	Clark et al., 1993	

Collaboratives/ Consortia (cont'd)	Types of strategies used in collaborative ventures: 1) *Cooperative* strategies are collective efforts undertaken to facilitate cooperative action toward the common goal. 2) *Maintenance* strategies are initiated by individual organizations for either "partnership maintenance" (aimed at maintaining cooperation with other organizations) or "organizational maintenance" (aimed at the day-to-day functioning of the organization or reaching collaborative goals). 3) *Pressure* strategies are aimed at compelling members to act in ways that advance the goals of the collaboration.	Clark et al., 1993	
	Consortia and collaboratives are the banding together of "similar organizations ... to benefit more from their collective actions than they could as individual players."	Kreuter & Lezin, 1998	X
	Collaboration can be conceived as the highest of three levels of interagency activities: • *Cooperation/networking*: The most informal type of alliance, used primarily for resource exchange. • *Coordination*: More structured, used for increasing efficiency and resource exchange. • *Collaboration*: The "most sophisticated," entailing common goals, exchange of resources, planning, implementing, and evaluating services, and the power of members to commit resources and change policies/procedures in the interest of common goals.	McCoy-Thompson, 1994	
	Alter & Hage's stages and levels of collaboration: 1) *Obligational* network: Collaboration consists mainly of information exchange through personal communication among staff members. 2) *Promotional* network: Organizations contribute resources, feel an obligation to the group, work together to address a common problem, and retain autonomy, since decision-making is limited to the identified common problem. 3) *Systemic* network: The problems addressed are more complex and require resources from outside the coalition/collaborative structure. Organizations are less autonomous, and decisions are made by the coalition/collaborative.	In Parker et al., 1998	X

Measurement and Evaluation Methods			
Community Diagnosis	A method of assessing a community's needs and characteristics that takes into account its social dynamics and other factors affecting internal problem-solving capacity. Community diagnosis may couple the assessment process with community organizing and capacity building. Community mapping can be used to supplement the assessment and illustrate its results.	Eng & Blanchard, 1990-91	
Community Story	A community-controlled ethnographic approach to evaluation, the community story describes the development of community change activities for use in continuous monitoring and improvement.	Dixon, 1995; Dixon & Sindall, 1994	
Community Mapping	In community mapping, the assets of a community are diagrammed in primary, secondary, and potential building blocks according to their source and locus of control (i.e., within or external to the community). Community mapping can be used as part of a community diagnosis.	CDC, 1998; McKnight & Kretzmann, 1990	X
Participatory Evaluation	A participatory evaluation serves dual purposes – to provide evaluation data on process and outcome measures and to provide feedback to the coalition as part of a continuous cycle of quality improvement. The evaluation team thus works closely with the coalition membership to develop evaluation measures and collect data.	Francisco, Paine, & Fawcett, 1993	X
Participatory Action Research	A cyclical model of community assessment, intervention, and evaluation based on an empowerment perspective that balances the goals of research and practice.	Israel et al., 1994	X
Participatory Research	"Systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change."	Institute of Health Promotion Research, 1999	
Empowerment Evaluation	A process of program self-evaluation that promotes self-determination and continuous monitoring for improvement. Empowerment evaluation is meant to be used at the program level, but can be applied to the community level as well.	Fetterman, Kaftarian, and Wandersman, 1996	X
Triangulation	The use of multiple types and sources of data, combining, for example, quantitative and qualitative data collection methods to obtain complementary information.	Goodman et al., 1996	X

Authors Matched to Selected Key Concepts

	Defining Community	Community Involvement	Community Competence	Community Empowerment	Community Readiness	Community Capacity	Social Capital	Community Action/ Organizing	Collaborative Problem Solving	Community Mapping/ Diagnosis	Measurement and Evaluation Issues*
Aronson, O'Campo, & Peak, 1996										X	X
The Aspen Institute, 1996[‡] (p. 51)						X					X
Bailey & Koney, 1995									X		
Baker & Teaser-Polk, 1998	X	X				X					X
Bazzoli et al., 1997									X		
Bruner, 1998									X	X	X
Bruner & Chavez, 1998	X	X				X		X		X	
Butterfoss, Goodman, & Wandersman, 1993									X		X
CDC, 1998	X	X		X		X		X	X	X	
Clark et al., 1993									X		
Connell et al., 1995	X	X									X

[‡]Citations in italics indicate that an expanded summary of the resource is included in Part III, and the page number follows.

	Defining Community	Community Involvement	Community Competence	Community Empowerment	Community Readiness	Community Capacity	Social Capital	Community Action/ Organizing	Collaborative Problem Solving	Community Mapping/ Diagnosis	Measurement and Evaluation Issues*
Coombe, 1997				X				X			X
Cottrell, 1976			X								
Denham, Quinn, & Gamble, 1998			X					X			
Dixon, 1995		X	X								X
Dixon & Sindall, 1994		X	X								X
Easterling et al., 1998 (p. 46)				X		X					
Eisen, 1994		X		X				X		X	X
Eng & Blanchard, 1990-91											
Eng & Parker, 1994			X	X							X
Fawcett et al., 1995				X					X		
Fetterman, Kaftarian, & Wandersman, 1996 (p. 52)				X							X
Florin, Mitchell, & Stevenson, 1993									X		X

	Defining Community	Community Involvement	Community Competence	Community Empowerment	Community Readiness	Community Capacity	Social Capital	Community Action/ Organizing	Collaborative Problem Solving	Community Mapping/ Diagnosis	Measurement and Evaluation Issues*
Francisco, Paine, & Fawcett, 1993									X		X
Gatz et al., 1982			X								X
Goeppinger & Baglioni, 1985 (p. 38)			X								X
Goodman & Steckler, 1989											X
Goodman et al., 1993											X
Goodman et al., 1996 (p. 47)									X		X
Goodman et al., 1998			X	X	X	X					X
Haglund, Weisbrod, & Bracht, 1990	X		X		X					X	X
Hancock et al., 1997		X						X			X
Howell et al., 1998 (p. 37)		X		X					X		
Institute of Health Promotion Research, 1999											X
Institute of Medicine, 1997						X			X		X

	Defining Community	Community Involvement	Community Competence	Community Empowerment	Community Readiness	Community Capacity	Social Capital	Community Action/ Organizing	Collaborative Problem Solving	Community Mapping/ Diagnosis	Measurement and Evaluation Issues*
Iscoe, 1974			X								
Israel et al., 1994	X			X							X
Jewkes & Murcott, 1996	X										
Jewkes & Murcott, 1998	X	X									
Jones & Silva, 1991			X					X	X		
Kegler et al., 1998						X			X		X
Knight, Johnson, & Holbert, 1990-91 (p. 40)			X								X
Kreuter & Lezin, 1998		X					X		X		X
Kumpfer et al., 1993									X		
McArthur, 1995		X									
McCoy-Thompson, 1994		X							X		
McKnight & Kretzmann, 1990 (p. 53)		X						X		X	X

	Defining Community	Community Involvement	Community Competence	Community Empowerment	Community Readiness	Community Capacity	Social Capital	Community Action/ Organizing	Collaborative Problem Solving	Community Mapping/ Diagnosis	Measurement and Evaluation Issues*
McLeroy et al., 1994									X		
McMillan et al., 1995				X					X		
Nezlek & Galano, 1993									X		
Oetting et al., 1995					X						X
Parker et al., 1998									X		
Peyrot & Smith, 1998 (p. 43)					X						X
Scheirer, 1993											X
Walter, 1997	X							X			
Wandersman, Goodman, & Butterfoss, 1997 (p. 49)									X		
Wandersman et al., 1996									X		X
Wilson, 1997				X			X	X	X		

Annotated Bibliography

DEFINING AND INVOLVING THE COMMUNITY

Bruner C, Chavez M. *Getting To The Grassroots: Neighborhood Organizing and Mobilization. Volume 6: Community Collaboration Guidebook Series*. National Center for Service Integration Clearinghouse, 1998.

This document, part of a series devoted to community collaboratives, provides guidance on neighborhood development and community ownership of initiatives. The authors briefly describe the meaning of neighborhood, which they distinguish from community, before describing the role of collaboratives in neighborhood organizing. Specific guidelines are offered for creating true partnerships and building neighborhood capacity. Appendices address more fully the concepts of community, neighborhood, and social capital; Arnstein's (1969) "Ladder of Citizen Participation," a hierarchy of community involvement in initiatives; methods of obtaining residents' input in community assessments; **McKnight and Kretzmann's (1990)**[‡] guide to mapping community capacity; community organizing; employing neighborhood residents; and the role of government in community capacity building.

Available from Child and Family Policy Center, 218 Sixth Avenue, Suite 1021, Des Moines, IA 50309-4006, (515) 280-9027, fax (515) 244-8997.

❖ **Howell EM, Devaney B, McCormick M, Raykovich KT. Community involvement in the Healthy Start Program. *Journal of Health Politics, Policy and Law* 1998; 23:291-317.**

Howell et al. briefly describe the historical context for community participation in health promotion programs and other community organizing activities and the equivocal empirical support for a positive effect on program development. Using a case study approach, national evaluators examined the approaches to community involvement taken by local Healthy Start programs. Interviews with project staff covered topics including community context (e.g., demographics, characteristics of the health care delivery system) and the characteristics and development of Healthy Start Consortia. The study revealed two approaches to community involvement, the service consortium model and the community empowerment model. For each model, the paper presents a pictorial description of the relationships among strategies for involving community members, the intermediate outcome measures associated with these strategies, and the final outcome measure of reduction in the infant mortality rate. The evaluators draw a series of conclusions about the stumbling blocks to involvement of community members and the often negative effects of consumer participation on program development. They address issues related to involvement of community providers, nonprofessional community members, community institutions and businesses, and economic development strategies, including employment of local residents by the program.

Jewkes R, Murcott A. Meanings of community. *Social Science and Medicine* 1996; 43:555-563.

In this paper, the authors address the conflicting definitions of "community" employed in health promotion programs and the consequences of the choice of meanings. They review the history of the concept in the social sciences literature dating from the late nineteenth century and note that the health literature shares with the social sciences a decided lack of consensus about what constitutes a community, even while asserting its importance. Through interviews, non-participant observation, and document review, the authors examined the implicit meanings of community for health promotion workers engaged in community mobilization efforts. Common to the varied meanings identified (28 in all) was the use of a central point of reference – the organization or individual engaging in the health promotion initiative – to define the community and its members. Definition by these non-members of

[‡]References in bold indicate resources that are included in this guide.

the community also tended to be premised on an assumption of a shared sense of community among members – an assumption that often proves false.

Jewkes R, Murcott A. Community representatives: Representing the "community"? *Social Science and Medicine* 1998; 46:843-858.

Jewkes and Murcott explore the uses and interpretations of "community" and "community participation" in community health promotion projects in the United Kingdom. They note that, despite debate about the meaning of community in the academic literature, in practice, programs and policies treat the meaning of community as self-evident, while defining it implicitly in the manner most expedient to the problem at hand. The authors describe a process whereby "community representatives" were chosen without assurances that they actually represented the voice of the community, bolstering a "monopoly on group leadership." They conclude that definitions of community participation may have to be context-specific, differing, for example, by the level of change targeted.

McArthur A. The active involvement of local residents in strategic community partnerships. *Policy and Politics* 1995; 23:61-71.

Though this article addresses community participation in the context of British urban development policy, its observations about the reasons for community involvement, the methods of inclusion, the influence of community members in partnerships, and the outcomes of community participation are relevant to U.S. community collaboratives as well. The authors note some of the stumbling blocks to community involvement and highlight potential impacts, including increased accessibility and local orientation of programs, shaping policy and agendas, and sparking new initiatives.

Walter CL. Community building practice: A conceptual framework. In Minkler M (ed.). *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press, 1997, pp. 68-83.

Walter broadens the notion of community from a contained unit to a multidimensional system encompassing the interactions of people and organizations across horizontal and vertical levels – including those traditionally viewed as external to the community. In this conception, community is characterized not just by people and organizations, but by actions, context, and even consciousness (perceptions and cultural constructs) as well. Community is thus variable and permeable, being shaped and re-shaped continuously by changing actions and relationships; "what community is can look very different depending on where one is sitting" (p. 72). The author describes the consequences of this re-conceptualization of community for community building practice: an emphasis on community, rather than *the* community; a more complex model on which to base practice; a greater concern for community-building activities; and a focus on mutual exchange rather than intervention. She then focuses more specifically on the implications of this theoretical orientation for community building practice and links different approaches (e.g. community development, community action) to the different dimensions of community.

COMMUNITY CAPACITY

Baker EA, Teaser-Polk C. Measuring community capacity: Where do we go from here? Health Education and Behavior 1998;25(3):279-283.

Commenting on **Goodman et al.'s (1998)** work, Baker and Teaser-Polk set forth some of the issues that should be considered as professionals and community members further attempt to develop measures of community capacity. The authors address the implications of several key issues for measuring community capacity: the definition of the community's boundaries, levels, and stages of development; the use of formal versus informal leaders; the barriers and costs of participation; and community input in operationalizing the dimensions of community capacity.

❖ = *An expanded summary is included in Part III.*

❖ **Easterling D, Gallagher K, Drisko J, Johnson T. Promoting health by building community capacity: Evidence and Implications for Grantmakers. Denver, CO: The Colorado Trust, 1998.**

As part of its larger mission of health promotion, The Colorado Trust funds initiatives which promote community capacity building. This report makes a case for the effect of community capacity on a population's health status. The Trust offers a definition of community capacity that is based on its experience with community-based programs and encompasses five broad dimensions. The report provides evidence from the research literature linking elements of community capacity to health outcomes. Finally, it identifies some general strategies for building community capacity, including community development and community empowerment.

Available from The Colorado Trust, 1600 Sherman Street, Denver, CO 80203, (303) 837-1200.

Goodman RM, Speers MA, McLeroy K, Fawcett S, Kegler M, Parker E, Smith SR, Sterling TD, Wallerstein N. Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior* 1998;25(3):258-278.

Goodman et al. present the work of a 1995 CDC symposium convened to delineate the elements of community capacity, with an aim toward aiding in the development of methods to operationalize and measure the construct. The paper distinguishes community capacity from the related concepts of community empowerment, competence, and readiness; details ten dimensions of community capacity; and describes the relationships among these dimensions. The authors discuss the use of the dimensions as a basis for discussion by community groups engaged in capacity-building activities and as a first step in efforts to operationalize measures of capacity for community assessment.

SOCIAL CAPITAL

Wilson PA. Building social capital: A learning agenda for the twenty-first century. *Urban Studies* 1997; 34:745-760.

While technically not the equivalent of community capacity, the concept of social capital consists of several related components: inter-personal trust and commitment, civic engagement, and organizational capacity. Wilson uses social capital as a unifying concept, providing the basis for a broad philosophy related to the importance of community building for community development. Drawing from disciplines as diverse as business and history, she addresses the creation of social capital and identifies tools and methods that can assist professionals in growing from technical experts to facilitators. In the process, Wilson touches on social learning theory and its outgrowths, participatory action research, organizational development, dynamic systems theory, and social mobilization – all built to some extent on the principles of non-horizontal power relationships, knowledge residing in the community, and the transformative effect of social networks.

COMMUNITY COMPETENCE

Cottrell LS. The competent community. In Kaplan BJ, Wilson RN, Leighton AH (eds.), *Further Explorations in Social Psychiatry*. New York: Basic Books, 1976, pp. 195-209.

Cottrell was one of the first to translate the idea of individual competence to the level of the community. In this chapter, Cottrell describes how the concept of community competence emerged from early efforts at comprehensive, community-based initiatives targeting juvenile delinquency and crime and sets forth the skills necessary for effective collective problem solving. He then describes in detail eight conditions of community competence.

Denham A, Quinn SC, Gamble D. Community organizing for health promotion in the rural South: An exploration of community competence. *Family and Community Health* 1998; 21:1-21.

This article describes the results of a qualitative study on the effects of community organizing on community competence. The researchers interviewed 11 grass-roots community organizers using questions derived from **Eng and Parker (1994)** and based on **Cottrell's (1976)** eight dimensions of community competence, with the addition of social support and leadership development. The interviews covered the participants' perceptions of their communities' current levels of competence and the degree to which community competence had changed since they began their community organizing efforts. The article reports in detail the results of the interviews for each dimension assessed and suggests possible mechanisms whereby community organizing acts to increase capacity for each dimension.

Eng E, Parker E. Measuring community competence in the Mississippi Delta: The interface between program evaluation and empowerment. *Health Education Quarterly* 1994;21(2):199-220.

Eng and Parker report on the evaluation of a health promotion program that had at its roots a "community empowerment agenda," or the strong belief in the necessity of community ownership and the obligation of the program and its evaluation to promote community capacity building. This article focuses on one of three components of the initiative, the use of lay community health advisors to mobilize residents' responses to community problems and build community competence. The authors describe the different conceptualizations of community competence found in **Cottrell (1976)**, **Iscoe (1974)**, and Hurley, Barbarin, and Mitchell (1981), noting how these and other researchers have operationalized and measured community competence. The authors discuss the major problems encountered in previous measurements of community competence. The action research approach to developing the measures used in this study is described and the final survey items are included. The methods and results of the instrument's field testing are detailed.

Gatz M, Barbarin O, Tyler F, Mitchell RE, Moran JA, Wirzbicki PJ, Crawford J, Engelman A. Enhancement of individual and community competence: the older adult as community worker. *American Journal of Community Psychology* 1982; 10:291-303.

This article details the results of a primary prevention program aimed at increasing the individual competence and competence within the community of both residents and community health workers. The definition of community competence was based on the work of **Iscoe (1974)** and Hurley, Barbarin, and Mitchell (1981), focusing on access to and utilization of resources. The authors describe in detail the items used to measure community competence, including ratings of community strengths and needs, knowledge about five community agencies, hypothetical responses to community problems, and sources of information about community services. Pre- and post-intervention scores are reported and the relationship between individual and community competence is described.

❖ **Goeppinger J, Baglioni AJ. Community competence: A positive approach to needs assessment. *American Journal of Community Psychology* 1985; 13:507-523.**

Goeppinger and Baglioni report on a field test of survey items assessing community competence, based on **Cottrell's (1976)** model, which were administered as part of a Community Residents Survey in five towns. Survey items representing six of Cottrell's eight dimensions of community competence were found to discriminate among the communities. Factor analysis revealed four factors explaining 35 percent of the variance: democratic participation style, crime, resource adequacy and use, and decision-making interactions. Although these factors do not correspond exactly to Cottrell's model, the authors describe the overlap between the two conceptualizations. The authors conclude by describing the problems entailed in the measurement of competence at the community level. The survey items pertaining to community competence are attached as an appendix to the article.

❖ = *An expanded summary is included in Part III.*

Iscoe I. Community psychology and the competent community. *American Psychologist* 1974; 29:607-613.

Like **Cottrell (1976)**, Iscoe's work was central to the original development of the concept of community competence. Iscoe describes community competence as relating to the development and use of resources. In this article, he does not so much detail the conditions of community competence as make a case for the importance of attention to it in developing and evaluating human services interventions.

❖ **Knight EA, Johnson HH, Holbert D. Analysis of the competent community: Support for the community organization role of the health educator. *International Quarterly of Community Health Education* 1990-91; 11:145-154.**

The authors attempt to establish a link between community competence and population health status, defined by county-level years of productive life lost (YPLL). To assess community competence, representatives of social service agencies in 33 eastern North Carolina counties were surveyed about resource availability, citizen participation, coordination of services, and frequency of networking activities in their counties. Comparisons of rankings for community competence with rates of YPLL produced moderate support for an association between community competence and health status. Further analysis supported this trend, but without statistically significant results. The authors conclude that the competence of the provider/organizational community does impact population health status, with its level of influence varying by the dimension of competence.

COMMUNITY EMPOWERMENT

Eisen A. Survey of neighborhood-based, comprehensive community empowerment initiatives. *Health Education Quarterly* 1994; 21:235-252.

Reporting on a study of 17 initiatives, Eisen explores how program planners put community empowerment into practice. She first elaborates on the meanings of community empowerment and two other concepts intrinsic to these initiatives, comprehensiveness and neighborhood-as-base. The history of the initiatives is then outlined and their target neighborhoods described in detail. Eisen addresses the participation of community members, the strategies used by the initiatives to promote empowerment, the relationships between initiatives and their funders, and the initiatives' outcomes. She closes by discussing potential criteria for evaluating the process and outcomes of community empowerment initiatives and by posing several questions about the factors which influence the success of initiatives.

Fawcett SB, Paine-Andrews A, Francisco VT, Schultz JA, Richter KP, Lewis RK, Williams EL, Harris KJ, Berkley JY, Fisher JL, Lopez CM. Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology* 1995; 23:677-697.

The authors present a model of community empowerment in which relationships among persons, groups, and environmental context influence the outcomes and capacity for empowerment of community partnerships. Their framework for collaborative empowerment consists of five components: 1) collaborative planning; 2) community action; 3) community change; 4) community capacity and outcomes; and 5) adaptation, renewal, and institutionalization. Much of the article is devoted to citing enabling activities for boosting community empowerment and describing applications of the model in community coalitions.

Israel BA, Checkoway B, Schulz A, Zimmerman M. Health education and community empowerment: Conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education Quarterly* 1994; 21:149-170.

This article aims to clarify the definition of empowerment across levels and provide a basis for measurement of empowerment at the community level. The authors first outline the definition of community on which their work is

based. The meanings of empowerment at the individual, organizational, and community levels are explored, and relationships among the three levels are noted. The conceptual link between community empowerment and health status is examined in detail. The authors then report on their development of an instrument for the measurement of multi-level community empowerment. Twelve questions incorporated into a larger survey of residents of the Detroit area assessed individuals' perceptions of both their own power within the community and the power of the community and its composite institutions within the larger society. Three subscales, corresponding to individual, organization, and community-level control, were formed based on factor analysis, and reliability statistics are reported. Important limitations are noted, including the scale's measurement of perceived, rather than actual, control and its reliance on individual-level, rather than collective, data. Finally, the authors provide guidance for integrating a community empowerment perspective into health education practice and research.

COMMUNITY READINESS

Oetting ER, Donnermeyer JF, Plested BA, Edwards RW, Kelly K, Beauvais F. Assessing community readiness for prevention. *The International Journal of the Addictions* 1995; 30:659-683.

The authors describe a nine-stage model of community readiness and the development of five scales for use in measuring key aspects of readiness. Building on Prochaska et al.'s (1992) stages of individual psychological readiness for change, Rogers' (1983) stages of adoption of innovations, and the social action process of community development, this model delineates progressive collective orientations toward specific community problems: 1) community tolerance; 2) denial; 3) vague awareness; 4) preplanning; 5) preparation; 6) initiation; 7) institutionalization; 8) confirmation/expansion; and 9) professionalization. The five rating scales, developed for use with key informant interviews, measure level of readiness along five dimensions: prevention programming, knowledge about prevention programs, leadership and community involvement, knowledge about the problem, and funding for prevention. The full scales are included in the article and may be reproduced for use in research without permission of the authors.

❖ Peyrot M, Smith HL. Community readiness for substance abuse prevention: Toward a model of collective action. *Research in Community Sociology* 1998; 8:65-91.

Peyrot and Smith set forth a model of community-level readiness to engage in collective action that links community composition (aggregate residential characteristics), community context (drug and economic problems, neighborhood resources), and community organization (informal and formal neighborhood activities) to an independent measure of community readiness. Using structured key informant interviews and census data, the authors assessed the predictors of residents' willingness to undertake prevention activities and the number of activities they might initiate. Community composition explained eight percent of the variance in community readiness, community context explained seven percent of the variance not explained by community composition, and community organization explained six percent of the variance unaccounted for by the other two indices. The authors present the variables from each index that showed significant effects on community readiness.

COLLABORATIVE PROBLEM SOLVING

Bailey D, Koney KM. Community-based consortia: One model for creation and development. *Journal of Community Practice* 1995; 2:21-42.

The authors differentiate consortia from coalitions by their membership, with coalitions consisting of organizations, while consortia include individual members. The authors review the literature on organizational development and interorganizational collaboratives and coalitions, finding several common factors: leadership, membership, linkages

with external entities, mission, strategy, tasks, structure, and systems. Based on the literature and on experience with a local, community-based consortium, the authors outline four phases of consortium development: assembling, ordering, performing, and ending. The tasks and issues related to each phase are described, and "transitional themes" related to moving from one phase to the next are noted. The framework described in this article is particularly relevant for categorical programs, given that it draws on the experience of a single-issue consortium mandated by a funder, and resolving that issue leads to the final phase, ending.

Bazzoli GJ, Stein R, Alexander JA, Conrad DA, Sofaer S, Shortell SM. Public-private collaboration in health and human service delivery: Evidence from community partnerships. *The Milbank Quarterly* 1997; 75:533-561.

Bazzoli and colleagues explore the types and degrees of collaborative activity among public-private coalitions working with service delivery networks and examine the factors influencing that activity. The authors summarize the multi-disciplinary literature pertaining to community collaboration and propose a conceptual framework linking environmental context, the structure of the partnership, and the purposes of collaborative action. Based on this framework, the researchers used a survey of geographically diverse partnerships and other sources of data to produce a characterization of collaborative activities focused on three service factors: preventive health and educational services, usually provided collaboratively; traditional acute and chronic care services, usually provided individually; and behavioral health services, provided with partial collaboration. Specific activities of the partnerships fell into four categories: reports to the community; cost-containment; community health needs assessment; and coordination of services. Factors associated with the probability and extent of collaboration are presented for each category of collaborative service and collaborative action. Lastly, observations about the successes and stumbling blocks of these partnerships are noted.

CDC/ATSDR Committee on Community Engagement. *Principles of Community Engagement.* Public Health Practice Program Office, CDC, 1997.

This comprehensive look at community engagement, a community-based process of collaborative problem solving and health promotion, is geared toward professionals and community leaders interested in forming partnerships with community members and other organizations. Part one of the document explores the concept of community and other related theories and concepts: social ecology, cultural influences on health behaviors, community participation, community empowerment, capacity building, coalitions, benefits and costs of community participation, community organization, and stages of innovation. It concludes with a discussion of factors influencing the success of community engagement activities. Part two of the document describes nine principles meant to guide the development and implementation of community engagement activities. Finally, eight successful community collaborations are described as examples of the principles in action.

Available over the internet at www.cdc.gov/phppo/pce/index.htm.

Clark MN, Baker EA, Chawla A, Maru M. Sustaining collaborative problem solving: Strategies from a study in six Asian countries. *Health Education Research* 1993; 8:385-402.

Results are reported from seven case studies designed to identify strategies used to sustain collaborative activities and produce the desired outcomes. Beliefs intrinsic to the collaborative process and internal and external barriers which formed the backdrop for collaborative activities are described. Three types of strategies – cooperative, maintenance, and pressure – were planned for or emerged from the activities of collaborative projects. The purposes of each type of strategy and the specific tasks performed for each are outlined and demonstrated with examples from the case studies.

Jones B, Silva J. Problem solving, community building, and systems interaction: An integrated practice model for community development. *Journal of the Community Development Society* 1991; 22:1-21.

Jones and Silva propose a model of community development encompassing three distinct but interrelated processes: problem solving, community building, and systems interaction. The task-oriented problem solving process follows a course characterized by several stages from problem identification through implementation and evaluation. Community building also proceeds through a series of steps, but is aimed generally at creating ownership and networks for a community development organization. Finally, systems interaction refers to the relationships among an agent of change, the segment of the community affected, and the target of change, collectively making up an "action system" which provides direction for the intervention. A case study illustrates the model in practice.

Kreuter M, Lezin N. Are consortia/collaboratives effective in changing health status and health systems? A critical review of the literature. Health Resources and Services Administration, January 9, 1998.

Kreuter and Lezin first outline the differences between consortia, collaboratives, and coalitions and describe some of the reasons behind their formation. They then detail some of the few examples of collaboratives/coalitions showing demonstrable, positive effects on health status and health systems change. The authors outline the literature on stages of coalition development and corresponding factors related to effectiveness. They note the problems inherent in many evaluation strategies that may preclude demonstration of coalitions' impact and describe three tools that may be useful for evaluating the process and outcomes of coalitions/collaboratives: Formative Evaluation, Consultation, and Systems Technique (FORECAST); Framework for Evaluating and Improving Community Partnerships to Prevent CVD; and Prevention Plus III. The paper concludes with recommendations for improving technical assistance to coalitions and shifting the thinking about the purposes of collaborative work to encompass more intermediate outcomes.

McCoy-Thompson M. The Healthy Start Initiative: A Community-Driven Approach to Infant Mortality Reduction -- Volume I. Consortia Development. Arlington, VA: National Center for Education in Maternal and Child Health, 1994.

This document addresses the consortia required by the Healthy Start program to promote community ownership and guide the development of context-appropriate activities and services. The introduction includes a brief look at types of collective activities and five general factors influencing their development: climate, people, resources, processes, and policies. The document then addresses each factor specifically in relationship to the Healthy Start consortia. The following chapter details challenges that emerged in the development of the consortia: defining the consortia structure and process, involving community members, addressing race and class issues, and promoting economic development. Finally, the document offers recommendations for the future of the consortia.

Available from the National Maternal and Child Health Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, Virginia 22102, (703) 821-8955 ext. 254 or 265, fax (703) 821-2098.

COMMUNITY COALITIONS

Butterfoss FD, Goodman R, Wandersman A. Community coalitions for prevention and health promotion. *Health Education Research* 1993; 8:315-330.

Butterfoss, Goodman, and Wandersman synthesize the literature on the use and characteristics of coalitions in order to draw attention to the areas of research still lacking. They devote considerable space to exploring the different definitions and configurations of coalitions. They then describe the stages of coalition development along with the factors influencing effectiveness at each stage. The authors point to the paucity of research on factors affecting the success of coalitions in meeting their original goals and objectives and highlight the need for development of methods to measure the long-term, systems-level impacts of coalitions. Finally, they identify several areas of research regarding coalition characteristics and functioning that would elucidate the principles guiding effective coalition use.

Florin P, Mitchell R, Stevenson J. Identifying training and technical assistance needs in community coalitions: A developmental approach. *Health Education Research* 1993; 8:417-432.

Responding to communities' need for technical assistance in implementing coalitions and the general absence of empirical data guiding approaches to providing this assistance, the authors set forth a model of the stages of coalition development accompanied by the tasks required by each stage. This model formed the basis for a process and implementation evaluation of 35 local substance abuse prevention coalitions in the early stages of development. Data sources and data collection methods related specifically to training and technical assistance needs are described. Characterizations of the coalitions at each early stage of development are detailed along with their implications for technical assistance and training. The authors conclude by recommending the use of regional intermediary organizations and "enabling systems" for supporting community coalitions.

Francisco VT, Fawcett SB, Wolff TJ, Foster DL. Toward a research-based typology of health and human service coalitions. Amherst, MA: AHEC/Community Partners, 1996.

This document describes the use of a coalition evaluation system (see also Francisco, Paine, & Fawcett, 1993, below) in developing a typology of community coalitions. Case studies were conducted of five coalitions using both qualitative and quantitative indicators of coalition context, process, outputs, and outcomes to reflect the development of coalition functioning over time. Based on these studies, the authors produce a general classification of coalitions as 1) planning coalitions, 2) support networks for agencies, 3) service providers to the community, 4) catalysts for change, or 5) hybrid coalitions. The document includes descriptions of the coalition types, a framework relating the typology to the products of the coalition process, and descriptions of the measurement instruments used. These instruments included a monitoring system tracking coalition activities and outputs, a constituent survey on coalition functioning, and key informant interviews about critical events in the coalition's history.

Available from AHEC/Community Partners, 24 South Prospect Street, Amherst, MA 01002, (413) 253-4282, fax (413) 253-7131, www.ahecpartners.org.

Francisco VT, Paine AL, Fawcett SB. A methodology for monitoring and evaluating community health coalitions. *Health Education Research* 1993; 8:403-416.

A method of monitoring and evaluating community coalitions that promotes the participation of coalition members is described. The method uses event logs and semi-structured interviews to assess eight indicators of coalition process and outcomes: 1) number of members, 2) planning products, 3) financial resources, 4) dollars obtained, 5) volunteer recruitment, 6) service provision, 7) community actions, and 8) community changes. Definitions of variables, descriptions of data collection methods, and methods of analysis are presented, and the evaluations of two community coalitions are used as examples. Finally, the authors suggest several other methodologies that can complement the one described here for a comprehensive evaluation.

❖ **Goodman RM, Wandersman A, Chinman M, Imm P, Morrissey E. An ecological assessment of community based interventions for prevention and health promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology* 1996; 24:33-61.**

An ecological approach to evaluating community coalitions is conceived as one that encompasses multiple social levels, multiple stages of community or coalition readiness, and multiple sources of data. The article first synthesizes the literature on these conditions and then describes the evaluation of a local substance abuse prevention coalition. Specific methods and instruments appropriate to each stage of coalition development are described. The authors note the opportunities for capacity building and ongoing improvement of coalitions that are made possible by the interaction of coalition members with the evaluation.

Kegler MC, Steckler A, McLeroy K, Malek SH. Factors that contribute to effective community health promotion coalitions: A study of 10 Project ASSIST coalitions in North Carolina. *Health Education and Behavior* 1998; 25:338-353.

This article examines the effect of coalition factors (operational processes and structural characteristics) and community capacity on coalition effectiveness in local tobacco control coalitions. A detailed conceptual framework is provided, as are full descriptions of each factor and its scoring. A survey instrument measuring coalition and community factors and two outcomes, member satisfaction and member participation, is notable for using a truly community-level, albeit limited, measure of community capacity, defined by the history of the community in tobacco control activities. Methods of assessing other outcomes are also described, including instruments developed to facilitate systematic review of coalitions' action plans and implementation of planned activities. The remainder of the paper is devoted to reporting the relationships between coalition and community factors and coalition effectiveness.

Kumpfer KL, Turner C, Hopkins R, Librett J. Leadership and team effectiveness in community coalitions for the prevention of alcohol and other drug abuse. *Health Education Research* 1993; 8:359-374.

This article aims to fill partially the gap in empirical, as opposed to case study, evidence about the factors influencing coalition effectiveness. Specifically, it reports the results of an exploratory test of a theoretical model linking leadership style, member satisfaction, and "team" (i.e., subcommittee) self-efficacy to team effectiveness, using data from a substance abuse prevention coalition that merged a top-down, professionally-driven approach with a bottom-up, community-driven approach. Brief reviews of the literature on sense of community, coalition leadership, empowerment, and team self-efficacy are provided.

McLeroy KR, Kegler M, Steckler A, Burdine JM, Wisotzky M. Community coalitions for health promotion: Summary and further reflections. *Health Education Research* 1994; 9:1-11.

This paper summarizes the journal's special issue on the state of knowledge about community coalitions, which presented empirically-based articles on coalition development, operation, and evaluation. The authors present a simple diagram of coalition development based on key assumptions found in the coalition literature, and they synthesize the theme issue's contributions to the understanding of a variety of factors impacting coalition success. Finally, they provide lengthy discussions of four issues for which questions remain in the literature: the nature and lifespan of coalitions, the success and outcomes of coalitions, the ways in which contextual factors influence the development and effectiveness of coalitions, and the ways in which factors internal to the coalition impact their development and success.

McMillan B, Florin P, Stevenson J, Kerman B, Mitchell RE. Empowerment praxis in community coalitions. *American Journal of Community Psychology* 1995; 23:699-727.

In a study of 35 community coalitions for substance abuse prevention, McMillan et al. assess the effects of coalition characteristics on the psychological empowerment of coalition members, the collective empowerment of members, and the coalition's organizational empowerment. Following an exploration of the conceptual basis for these empowerment constructs, the authors describe in depth a survey and interview instruments assessing psychological and organizational empowerment (the dependent variables) and perceptions of community problems, sense of community, coalition participation, and organizational climate (independent variables). The results lend support to a strong link between organizational context and psychological empowerment, an effect of both participation and organizational climate on the collective empowerment of coalition members, and a relationship between an organization's ability to empower its members and its success in influencing its environment.

❖ = *An expanded summary is included in Part III.*

Parker EA, Eng E, Laraia B, Ammerman A, Dodds J, Margolis L, Cross A. Coalition building for prevention: Lessons learned from the North Carolina Community-Based Public Health Initiative. *Journal of Public Health Management Practice* 1998; 4:25-36.

The North Carolina Community-Based Public Health Initiative (NC CBPHI) was a consortium of four county-level coalitions which took a broad-based approach to improving health, health systems, and community input in minority communities, rather than the categorical approach of many of the coalitions described in the literature. The authors report evaluation results related to coalition functioning and outcomes and compare their findings to those of other coalition evaluations. The "multiple case study participatory" evaluation design employed both quantitative and qualitative methods. The framework guiding the evaluation, Alter and Hage's stages and levels of interorganizational networks (1992), is described and compared with the stages of coalition development advanced by **Butterfoss et al. (1993)** and **Florin et al. (1993)**. Six factors emerged from the evaluation as having had an impact on the functioning and success of the coalitions, and these factors are discussed in detail. The authors discuss the advantages of a noncategorical approach and the benefits of working with community-based organizations as equal partners.

❖ **Wandersman A, Goodman RM, Butterfoss FD. Understanding coalitions and how they operate: An 'open systems' organizational framework. In Minkler M (ed.). *Community Organizing and Community Building for Health.* New Brunswick, NJ: Rutgers University Press, 1997, pp. 261-277.**

Katz and Kahn's (1978) open systems model of organizational operation and interaction with the environment is used to frame a theory of coalitions as "mechanisms for processing resources obtained from the environment into products that affect that environment" (p. 264). The framework treats coalitions as organizations and centers on four elements: 1) resource acquisition (internal and external resources), 2) maintenance subsystem (organizational structure and functioning), 3) production subsystem (goal-oriented and maintenance activities), and 4) external goal attainment.

Wandersman A, Valois R, Ochs L, de la Cruz D, Adkins E, Goodman RM. Toward a social ecology of community coalitions. *American Journal of Health Promotion* 1996; 10:299-307.

Community coalitions and other collaborative networks have emerged as promising vehicles for social ecological interventions, which aim "multiple interventions at multiple levels." The definitions and advantages of coalitions are presented, and three stages of coalition development are briefly described. Contextual factors (economic, demographic, political, and structural) influencing coalition functioning are noted and illustrated with examples from the field. The development of a survey instrument using key community leaders to measure awareness, concern, and change across multiple levels of the community is described. Lastly, the authors call for the development of a comprehensive framework for the interaction of contextual factors and coalition functioning.

Aronson RE, O'Campo PJ, Peak GL. The use of neighborhood mapping in community evaluation: The experience of the Baltimore City Healthy Start Evaluation. Working Paper, Johns Hopkins Population Center, Manuscript No. WP96-07, 1996.

This report from the Baltimore Healthy Start program evaluation provides an example of the use of mapping in assessing the community characteristics that may influence the outcomes or implementation of programs. The evaluation used mapping as part of a participatory (community involvement) community diagnosis to determine areas of greatest need, the "diversity of risk" within small high-risk areas, and changes in neighborhood characteristics over the course of the intervention. Examples of the maps produced in this project are included.

Available from the Hopkins Population Center, 615 North Wolfe Street, Baltimore, MD 21205, (410) 614-5222, fax (410) 614-7288. The full text is also available over the internet, at http://popctr.jhsph.edu/Papers/wp96-07.htm.

Eng E, Blanchard L. Action-oriented community diagnosis: A health education tool. *International Quarterly of Community Health Education* 1990-91; 11:93-110.

Community diagnosis is offered as one answer to the limitations of traditional needs assessments in program planning. Community diagnosis goes beyond an assessment of needs to take into account community characteristics and social dynamics that affect the community's capacity for collective action, an essential condition for interventions that must survive independently of an external agency. In "action-oriented community diagnosis," data collection and analysis serve also as a means of community organizing and building community problem-solving capacity. Detailed directions for carrying out this type of assessment are provided. A lengthy case example illustrates the process.

Haglund B, Weisbrod RR, Bracht N. Assessing the community: Its service needs, leadership, and readiness. In Bracht N (ed.). *Heath Promotion at the Community Level*. Newbury Park, CA: Sage Publications, 1990, pp. 91-108.

This chapter provides a broad overview of the meaning, uses, and components of community analysis, also called community diagnosis, mapping, or needs assessment. It distinguishes community diagnosis from the community development or community organizing approach to assessment, although they are clearly interrelated. The chapter touches on objectives, research questions, quantitative and qualitative methods, and data sources for use in community analysis. The authors suggest that a crucial component of community analysis is an assessment of the community's readiness for change, explaining readiness with reference to **Cottrell's (1976)** conceptualization of community competence. An appendix lists key contacts and agencies to include in a community assessment and suggests data to be gathered from each.

❖**McKnight JL, Kretzmann JP. *Mapping Community Capacity*. Evanston, IL: Institute for Policy Research, Northwestern University, 1990.**

McKnight and Kretzmann propose a capacity-oriented approach to community building beginning with the creation of a Neighborhood Assets Map. Offered as an alternative to the negative focus of traditional needs assessment surveys, the assets map lays the groundwork for community development efforts led by community residents. The map is composed of "primary building blocks," for neighborhood assets and capacities that are controlled by residents, "secondary building blocks," for assets and capacities that are located in the neighborhood but controlled by outsiders, and "potential building blocks," for assets and capacities that are located outside of the neighborhood and controlled by outsiders.

Available over the internet at www.nwu.edu/IPR/publications/mcc.html.

❖ The Aspen Institute, Rural Economic Policy Program. Measuring community capacity building: A workbook-in-progress for rural communities (version 3-96). The Aspen Institute, 1996.

Although targeted to rural communities, this publication is applicable to any community interested in documenting its capacity-building efforts. The definition of capacity is based on commitment, resources, and skills. The guidebook leads the user through an explicit, easy-to-follow process for assessing eight outcomes of community capacity building. Aside from brief explanations of key terms and simple steps for putting the workbook to use, the bulk of the document is divided into sections detailing each outcome. The outcomes are broken down into indicators and subindicators and then linked to specific measures that can be chosen from based on the interests of the community.

Available from The Aspen Institute Publications Office, P.O. Box 222, Queenstown, MD 21658, fax (410) 827-9174.

Bruner C. *Defining the prize: From Agreed-Upon Outcomes To Results-Based Accountability. Volume 2: Community Collaboration Guidebook Series*. National Center for Service Integration Clearinghouse, 1998.

This guidebook makes a case for the use of outcome indicators to guide the development of initiatives and to increase their accountability. It opens with definitions of outcomes, indicators, and performance measures and provides guidance for selecting outcomes and indicators. It emphasizes the use of outcomes and indicators in the development of strategic plans, with community assessments pinpointing strengths in addition to deficiencies. Issues related to using outcomes as the basis of systems of accountability are addressed. Finally, specific steps in implementing outcomes-based accountability are proposed. Appendices provide definitions of key terms; examples of outcomes and indicators related to child and family health; annotated citations for resources on using indicators of child well-being; a description of a collaborative model of reform; a description of **McKnight and Kretzmann's (1990)** tool for mapping community capacity; questions for use in evaluating comprehensive service reform initiatives; an annotated bibliography on assessing the benefits of comprehensive community reform efforts; and a discussion of measuring system accountability.

Available from Child and Family Policy Center, 218 Sixth Avenue, Suite 1021, Des Moines, IA 50309-4006, (515) 280-9027, fax (515) 244-8997.

Connell JP, Kubisch AC, Schorr LB, Weiss CH. *New Approaches to Evaluating Community Initiatives: Concepts, Methods, and Contexts.* Roundtable on Comprehensive Community Initiatives for Children and Families. New York, NY: The Aspen Institute, 1995.

This book addresses a wide array of issues concerning the evaluation of comprehensive community initiatives, which aim to bolster and coordinate services across a variety of domains (e.g. housing, health care, economic development) while promoting the empowerment of the community. The introductory chapter touches on some of the difficulties encountered in evaluating these types of initiatives. The next chapter outlines the history of evaluation science as applied to comprehensive community initiatives. It uses examples of actual evaluations to illustrate past functions of or approaches to evaluation – social learning, impact assessment, policy learning, and contextual analysis – and notes some lessons for current evaluation efforts. The following chapter proposes an alternative to the standard outcomes-based evaluation model, using the theories of change underlying initiatives as a basis. Next, the use of conceptual frameworks based on existing social science research to guide the design and evaluation of initiatives is explored. Methodological issues encountered in community-level evaluation are described in the subsequent chapter: linking outcomes to specific initiatives, selecting appropriate units of analysis, defining community boundaries, and selecting outcome measures. The chapter ends with research questions for use

[§]Many of the resources in preceding sections also contain measurement-related issues and instruments. Those included in this section focus principally on measurement/evaluation tools and perspectives.

in evaluating community-wide initiatives and steps to be taken in improving evaluation methodology. The following chapter addresses the use of indicators of child well-being, touching on the differences between outcome indicators and contextual indicators as well as some methodological concerns related to community-level indicators. Finally, the role of the evaluator, the purpose of the evaluation, and current strategies of evaluation are explored.

Available from The Aspen Institute, 345 East 46th Street, Suite 700, New York, NY 10017-3562, (212) 697-1261, fax (212) 697-2258.

Coombe CM. Using empowerment evaluation in community organizing and community-based health initiatives. In Minkler M (ed.). *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press, 1997, pp. 291-307.

Coombe describes an evaluation process designed as much to build capacity as to assess an initiative. He argues that traditional evaluation methods often undermine the objectives of community-building initiatives, while empowerment evaluation supports community ownership, organizational development, and institutionalization of programs through democratic and participatory means. Empowerment evaluation is explicitly designed to increase resources and skills across multiple levels while linking assessment to action. Coombe outlines a six-step empowerment evaluation process: 1) assessing community concerns and resources, 2) setting a mission and objectives, 3) developing strategies and action plans, 4) monitoring process and outcomes, 5) communicating information to relevant audiences, and 6) promoting adaptation and institutionalization – all undertaken with community members as key players and outside evaluators playing a supportive role.

Dixon J. Community stories and indicators for evaluating community development. *Community Development Journal* 1995; 30:327-336.

Dixon advocates for the use of community self-assessment to enhance the validity of evaluations of community development programs. She proposes the use of the "Community Story" as a formative evaluation tool, describing the developmental process in community-driven change activities for use in continuous monitoring and improvement. For the evaluation of externally-led activities which traditionally focus on accountability and tangible outcomes, Dixon describes assets-based indicators which correspond to the underlying values of specific community development outcomes.

Dixon J, Sindall C. Applying logics of change to the evaluation of community development in health promotion. *Health Promotion International* 1994; 9:297-309.

Dixon and Sindall take on the "differences between externally and internally generated change processes" and traditional perspectives on community ownership, maintaining that the trend toward using community-controlled process evaluations alongside professionally-driven outcome evaluations bypasses some important epistemological issues in the evaluation of community development programs. The authors describe three types of community change processes: community-led change, community programs (partnerships between external agencies and community agencies), and community interventions (implemented in a community by an external agency). Underlying these "logics of change" are "logics of rationality," which shape the values and assumptions of the community change approaches. The authors argue that the epistemological basis for each community change process should frame the evaluation approach, and they outline the evaluation approaches appropriate for each type of community change process. They note some of the problems inherent in current approaches to health standards and indicators, including the use of indicators that are individual-level rather than community-level and problem-oriented rather than strengths-oriented. Finally, they propose the use of community-controlled ethnography to develop a "community story" as part of a bottom-up evaluation approach.

❖ **Fetterman DM, Kaftarian SJ, Wandersman A, eds. *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage Publications, 1996.**

Empowerment evaluation fuses quantitative and qualitative methods in a process of program self-evaluation and improvement. The general steps involved include: 1) "taking stock," or assessment of program activities/components, strengths, and weaknesses; 2) setting goals that are linked directly to both program activities and outcomes; 3) developing strategies to reach objectives; and 4) documenting progress toward goals. Several chapters contribute easily adaptable frameworks based on the general empowerment evaluation model. What differentiates this method from other assessment processes is its basis in empowerment theory and its focus on self-determination; the role of the professional evaluator in empowerment evaluation is to train, facilitate, even to advocate, all with the goal of fostering self-sufficiency of the program in evaluation and monitoring. Many examples are presented of empowerment evaluation in practice, but with a focus on conceptual and methodological issues that are relevant to program types other than those presented as well. Part five of the book includes several chapters that provide evaluation instruments and techniques useful for both professional and nonprofessional evaluators.

Goodman RM, McLeroy KR, Steckler AB, Hoyle RH. Development of level of institutionalization scales for health promotion programs. *Health Education Quarterly* 1993; 20:161-178.

The authors present preliminary work on an instrument to measure the extent to which a program has become embedded within its host organization, or level of institutionalization. Borrowing from Yin's (1979) framework of passages and cycles and Katz and Kahn's (1978) conceptualization of organizational subsystems, Goodman et al. developed a matrix for classifying the level of institutionalization of a program based on both its extensiveness and intensiveness of institutionalization across the subsystems of an organization. Results supporting the construct validity of the scales are presented.

Goodman RM, Steckler A. A model for the institutionalization of health promotion programs. *Family and Community Health* 1989; 11:63-78.

Goodman and Steckler describe a model of program institutionalization, the final stage in a process of organizational "diffusion of innovations." Case studies of the passages and cycles achieved by ten health promotion programs revealed six factors related to program institutionalization: standard operating routines; six sequential "critical precursor conditions" moving from problem awareness to perceived benefit of a program; convergence of support leading to coalition-building; activities of a program advocate; mutual adaptation of program and organizational norms; and organizational fit.

Hancock L, Sanson-Fisher RW, Redman S, Burton R, Burton L, Butler J, Girgis A, Gibberd R, Hensley M, McClintock A, Reid A, Schofield M, Tripodi T, Walsh R. Community action for health promotion: A review of methods and outcomes 1990-1995. *American Journal of Preventive Medicine* 1997; 13:229-239.

The authors assess the utility of the community action approach to health promotion through a review of the evaluation literature. They define community action and discuss the advantages and disadvantages of this approach to health promotion. They present several criteria for scientific evaluation of community action interventions and note some common barriers to carrying out rigorous evaluation. A review of the literature on cancer and cardiovascular disease prevention programs revealed 13 evaluation studies. However, none of the studies met all of the criteria for scientifically rigorous evaluation, and those that met most of the criteria failed to show a great impact on health risk factors.

Institute of Health Promotion Research. *Guidelines And Categories For Classifying Participatory Research Projects In Health Promotion*. University of British Columbia, Canada, 1999.

The Institute of Health Promotion Research (IHPR), working in conjunction with experts in the field in Canada, developed a set of criteria characterizing participatory research projects – projects undertaken in collaboration with the study population and directed toward community change. Presented as a checklist with scaled answers, these guidelines are meant to be used both by researchers planning participatory projects and by funders assessing the degree to which projects adhere to participatory principles. Six general domains are assessed by specific questions or indicators, with responses scaled along a continuum: Participants and the nature of their involvement, Origin of the research question, Purpose of the research, Process and "contextomethodological" implications, Opportunities to address the issue of interest, and Nature of the research outcomes. The full set of guidelines is available for downloading on the IHPR's website.

Available over the internet at www.ihpr.ubc.ca/guidelines.html.

Institute of Medicine. *Improving Health in the Community: A Role for Performance Monitoring*. Washington, DC: National Academy Press, 1997.

This book addresses a community-oriented, collaborative process of health assessment and improvement that includes attention to the accountability of specific community entities. It advocates the use of a community health improvement process (CHIP) with complementary cycles of problem identification/prioritization and analysis/implementation. The book's chapters cover the "field model" of the determinants of health and its implications for communities; community-level accountability for performance and concepts related to the community change process; the CHIP framework, including the community and coalition capacities necessary for success of the process; selecting indicators for community health profiles and other measurement issues; and guidelines for developing and implementing the CHIP framework. Appendices include prototype performance indicator sets and discussions of methodological issues involved in using performance indicators, issues involved in the use of performance monitoring in community health improvement activities, and a conceptual framework for community health improvement with examples of communities' experiences.

Available from National Academy Press, Box 285, 2101 Constitution Avenue NW, Washington, DC 20055, (800) 624-6242 or (202) 334-3313, www.nap.edu.

❖ *= An expanded summary is included in Part III.*

Scheirer MA. Are the level of institutionalization scales ready for "prime time?" A commentary on "Development of level of institutionalization (LoIn) scales for health promotion programs. *Health Education Quarterly* 1993; 20:179-183.

Scheirer comments on **Goodman et al.'s (1993)** Level of Institutionalization Scales, questioning how well the scale items represent the concepts they are supposed to measure, whether the eight scales included truly measure separate dimensions, and whether choice of respondent may influence the results. She concludes that the scales are not sufficiently well developed for use in general research or program assessments, but that research furthering the developing of the instrument is needed. The response of Goodman et al. to the critique is included.

Expanded Summaries
Of
Selected Resources

Howell EM, Devaney B, McCormick M, Raykovich KT. Community involvement in the Healthy Start Program. *Journal of Health Politics, Policy and Law* 1998; 23:291-317.

Overview: Two strategies for involving the community in Healthy Start infant mortality prevention programs are described and the implications of each are assessed.

Concepts: The authors briefly describe the history of community involvement in health programs, noting that the evidence for the effectiveness of community involvement activities is weak, due in part to inadequate evaluation methods and inconsistent conceptualization of community involvement. Nevertheless, community participation in the Healthy Start program was seen as essential to addressing community needs and was incorporated into the program through consortia of community members and providers. As with the guidelines for the program as a whole, the specifications for developing the consortia were left broad.

The evaluation revealed two main strategies, usually used in concert, to involve the community in Healthy Start consortia. The *service consortium model* primarily involves providers and other professionals and is oriented toward forming networks to improve the coordination of and access to services. The *community empowerment model* solicits participation through neighborhood-based groups, contracts with community-based organizations, employs residents as project staff, and generates economic development initiatives. By targeting poverty-related issues, the empowerment model attempts to move beyond traditional health services interventions to address the more underlying causes of infant mortality. However, evaluation of the community empowerment model is made difficult by the indirect links between strategies and these more distal health outcomes.

Measurement: As part of the national evaluation of Healthy Start, site visits were conducted at each of the original 15 projects, including observations of consortium meetings and review of prior meeting minutes and attendance lists. Interviews with project staff and consortia participants covered project structure, community context, the consortium, public information, outreach and case management, and service delivery.

The authors highlight several findings:

- Sustained efforts at community participation require a clear understanding of the purposes of involving the community.
- Projects were able to achieve only "token representation" of community residents in their central consortia, although community participation in local, neighborhood-based consortia was greater.
- Program goals must converge with the goals of providers and residents for involvement strategies to be effective. Relatedly, community participants may steer program goals toward issues unrelated or tangential to the program's mission.
- Community involvement is labor-intensive and may slow program development.
- Involving community residents may be more difficult than involving providers.

Use: Howell et al. provide useful information about the advantages and disadvantages of two very different approaches to maintaining a community orientation.

Goeppinger J, Baglioni AJ. Community competence: A positive approach to needs assessment. *American Journal of Community Psychology* 1985; 13:507-523.

Overview: Using a model of communities based on strengths rather than deficits, Goeppinger and Baglioni propose that interventions target the community's ability to utilize resources to address problems. This article demonstrates the use of a survey of community residents to assess the community's general capacity for problem solving.

Concepts: The authors base their assessment on **Cottrell's (1976)** model of community competence, refining it to allow for operationalizing and measuring the construct. They present other authors' definitions of community competence, suggesting that a common thread is the importance of "congruent perceptions" among community sectors for problem-solving. Goeppinger and Baglioni stress that individual competence is necessary but not sufficient for community competence, noting that the two constructs are frequently confused.

Cottrell's specification of eight dimensions of community competence provided a framework for the development of survey items:

- *Commitment* and a feeling of connection to the community;
- *Self-other awareness and clarity of situational definitions*, or accurate perceptions of divergent viewpoints;
- *Articulateness* of needs and perspectives;
- *Effective communication* based on common meanings and taking the view of the other;
- *Participation* of residents in achieving community goals;
- *Conflict containment and accommodation* in an open forum;
- *Management of relations with the larger society*, involving the mobilization of external resources; and
- *Machinery for facilitating participant interaction and decision-making*, including formalized, but flexible, rules and procedures.

Measurement: A survey containing 22 items assessing community competence was administered to residents from rural households chosen from clusters based on size and socioeconomic conditions. The items included in the final analysis are matched to the dimensions of community competence they are thought to represent in Table 1, below. The actual survey questions are included as an appendix to the article.

Field Testing: The authors analyzed the data for both the discriminatory power of items and the extent to which items represented Cottrell's 8-dimension model. Fourteen items were found to discriminate among the communities, using multiple one-way analysis of variance (see table 1 for the items with *F*-values). Those items which did not discriminate among communities (not listed here) were dropped from the analysis.

Only six of the eight dimensions of community competence were represented in the Community Residents Survey. Neither articulateness nor effective communication were represented; The authors suggest that these dimensions may actually convey one concept, and attempts to distinguish between the two hindered their adequate representation in the survey instrument.

Factor analysis revealed four factors accounting for 35 percent of the variance in the data: democratic participation style, crime, resource adequacy and use, and decision-making interactions. The authors draw parallels between these four factors and the dimensions in Cottrell's model, with democratic participation style representing machinery for facilitating participant interaction, management of relations with the larger society, and self-other awareness; resource adequacy and use representing commitment and participation, machinery for facilitating participant interaction, and self-other awareness; and crime and decision-making interactions representing conflict containment and accommodation. Goeppinger and Baglioni suggest that the decision-making interactions variable reflects "the essence of community competence," in that the two items loading on this factor measure the openness of debate about community problems and the reconciliation of differences.

Table 1. Dimensions Represented, Discriminatory Power, and Factor Loadings of Survey Items

Dimension Represented	Item	*F*	Factor (factor loading)
commitment	proportion of family members in community	6.18	none
participation	use of local services	18.07	resource adequacy and use (.456)
participation	organization membership	6.60	resource adequacy and use (.525)
commitment	pride in community appearance	3.49	resource adequacy and use (.300)
self-other awareness and clarity of situational definitions	adequacy of local services	5.64	resource adequacy and use (.390)
machinery for facilitating participant interaction and decision making	shared decision-making power	7.36	democratic participation and style (.412) and resource adequacy and use (.324)
self-other awareness and clarity of situational definitions	freedom of all residents to participate	7.92	democratic participation and style (.274) and resource adequacy and use (.254)
management of relations with larger society	residents attempt to exert influence on county	9.74	democratic participation style (.813)
machinery for facilitating participant interaction and decision making	residents attempt to exert influence on town	5.82	democratic participation style (.569)
management of relations with larger society	effective county representatives	3.68	democratic participation style (.295)
conflict containment and accommodation	speak out on issues	3.94	decision-making interactions (.671)
conflict containment and accommodation	work together on issues	7.02	decision-making interactions (.577)
conflict containment and accommodation	general crime is a problem	5.00	crime (.793)
conflict containment and accommodation	juvenile crime is a problem	7.31	crime (.711)

Adapted from Goeppinger & Baglioni, 1985.

Use: This survey instrument has informed more recent research on community competence (e.g., **Eng & Parker, 1994**). It illustrates one approach to measuring community-level factors, using individuals' perceptions of collective characteristics.

Knight EA, Johnson HH, Holbert D. Analysis of the competent community: support for the community organization role of the health educator. *International Quarterly of Community Health Education* 1991; 11:145-154.

Overview: In this study, the authors attempt to establish a link between community competence and population health status, using an agency, as opposed to resident, survey.

Concepts: The authors describe a competent community as one that engages in active problem solving and supports resources that contribute to residents' well-being. Characteristics of a competent community include "collaboration for integration of services and decision-making, which is facilitated by knowledge of other agencies and services, and participation by citizens in the functioning of organizations" (p. 146).

Measurement: A survey developed for use with representatives of social service agencies assessed the types of services they offer, their knowledge about other services available in the county, the extent of collaboration with other county agencies, and mechanisms for citizen input in planning.

Five variables measured community competence:

- *Resource availability:* Respondents were asked about the availability in the county of 104 services from five categories (preventive health, medical, housing, nutrition, and support services). The score consisted of the number of services either provided by respondents or identified as available from another organization by at least 50% of respondents. Each service counted only once, so the highest possible score was 104.

- *Participation:* The average number of citizen input mechanisms used by responding agencies, with the options including citizen advisory groups or boards, citizen surveys, information from community leaders or agencies, and others.

- *Integration:* The average number of organizations in the county with which the agency met regularly for planning and coordination of services.

- *Network intensity:* The frequency of the meetings identified in the integration variable. Six response categories were provided, from once per year to once per week, and the mean intensity scores for each agency were averaged to obtain a county score.

- *Knowledge of services:* The proportion of services available in the county, as identified in the resource availability variable, which the respondent knew to be available; the county score was obtained by averaging the scores for responding agencies.

Population health status was assessed by the rate of years of productive life lost (YPLL), defined as the number of years of life lost between age 1 and 65 from all causes, per 100,000 population.

Field Testing: The directors of county social service agencies in one state completed the survey. Each county was ranked for each of the five community competence variables and assigned a score of 0, 1, and 2 (for the bottom, middle, and top rankings). Counties were then ranked; those with composite scores greater than or equal to six and which did not fall into the bottom group on any variable comprised the top group; counties with composite scores less than or equal to four and which did not fall into the top group on any variable comprised the bottom group; and the remaining counties made up the middle group.

A comparison of rates of race-stratified YPLL by rankings on community competence revealed some trends. Counties with the highest community competence scores had lower white rates of YPLL than did the middle and bottom groups, although this trend was not evident for non-white rates of YPLL. Summing over all community

competence variables, small but statistically significant correlations were observed between composite scores and YPLL, with white and non-white rates of YPLL dropping with a rise in composite score. Further analysis supported the relationships between integration of services and white and non-white rates of YPLL and between knowledge of services and white YPLL, but these associations were not statistically significant.

The authors conclude that the competence of the provider/agency community does impact population health status, with its level of influence varying by dimension of competence. They suggest that knowledge of services and integration of services are particularly important, noting that these factors seem to benefit primarily whites; with the use of strategies utilizing "existing power structures, groups which have traditionally been excluded from these structures may not benefit" (p. 153).

Use: Knight, Johnson, and Holbert take a relatively original approach to measuring community competency. Their use of an agency-level survey and indicators based on the presence of actual community resources illustrates measurement at the community level.

Peyrot M, Smith HL. Community readiness for substance abuse prevention: Toward a model of collective action. *Research in Community Sociology* 1998; 8:65-91.

Overview: Peyrot and Smith propose and test a multi-factorial model of community readiness to address a common problem, using indices of community composition, community context, and community organization.

Concepts: Three types of factors are proposed to affect community readiness for prevention activities: community composition, community context, and community organization. In determining the factors likely to influence community readiness, the authors relied heavily on the research on community cohesion, or attachment, the most extensive related literature. Factors related to community attachment are presumed to be likely predictors of community readiness as well. (See Table 1.)

Measurement: Much of the prior research on community attachment and mobilization has relied on individual-level data, which do not take into account factors related to social organization. This study employed surveys of neighborhood leaders and census data aggregated to the level of the neighborhood.

Community composition was assessed through census data:

- households with married families
- vacant housing units
- owner-occupied housing
- education
- disability rate
- race/ethnicity
- age
- number of residents
- family income
- employment rate
- public assistance enrollment
- poverty rate

From interviews with neighborhood leaders, mean scores were calculated for each scale representing community context and organization variables (see Table 2).

Table 2. Survey Scale Items

Sets of Factors	Scales	Measures (# items)‡	Alpha
Community Context	Severity of neighborhood problems	alcohol and tobacco use (6)	.89
		economic and drug problems/"social decay" (9)	.94
	Availability of services	youth programs (3)	.84
		police services (2)	.66
		other programs (5)	.79
Community Organization	Cohesion	commitment and social relationships (5)	.81
	Neighborhood Organization	neighborhood formal organization (1)	____
		neighborhood informal organization (1)	____

‡Actual items and response scales are included in an appendix to the article.

Community readiness was assessed with three questions:

- "How many would be willing to join in neighborhood substance abuse prevention activities?" (almost none, few, some, many, or most)
- "What substance abuse prevention activities do you think your neighbors would be most willing to take part in?" (# of activities)
- "If your neighborhood had the necessary assistance, what other types of neighborhood strengthening activities would your neighbors be most interested in?" (# of activities)

Field Testing: Table 1 includes items shown to be related to community readiness. A path model, generated to represent the causal pathways among variables, confirmed that community composition, context, and organization affected community readiness.‡ Community composition explained eight percent of the variance in community readiness, community context explained seven percent of the variance not explained by community composition, and community organization explained six percent of the variance unaccounted for by the other two indices.

Use: This research provides a model for the assessment of community characteristics likely to affect success in establishing an intervention.

‡ The full path model identifies directions and degrees of influence among specific variables.

Table 1. Factors affecting community readiness.

Set of Factors	Definition	Determinants of Community Attachment	Statistically Significant Survey Items
Community Composition	characteristics of residents	• residential stability • marital status and number of children • income and education (equivocal) • age and race (equivocal)	• median family income • percent elderly (≥ 65 years)
Community Context	needs and resources	• crime rates and fear of crime • economic deterioration • nonresidential resources (public and private agencies and businesses)	*Social decay* • youth loitering • abandoned housing • adult unemployment • youth unemployment • drug-related violent crime • youth drug use • adult drug use • presence of "open air" drug markets • presence of houses with drug sales and use *Police services* • patrolling • response to resident calls
Community Organization	formal and informal neighborhood activities	• neighborhood associations • residential social networks	*Cohesion* • neighbors like living in neighborhood • neighbors want to stay in neighborhood • neighbors have friends in neighborhood • neighbors exchange favors • neighbors would help in an emergency *Formal neighborhood organization* • number of annual neighborhood association meetings *Informal neighborhood organization* • number of neighborhood events in last year

Adapted from Peyrot & Smith, 1998

Easterling D, Gallagher K, Drisko J, Johnson T. Promoting health by building community capacity: Evidence and Implications for Grantmakers. Denver, CO: The Colorado Trust, 1998.

Overview: As part of its larger mission of health promotion, The Colorado Trust funds initiatives that promote community capacity building. This report makes a case for the effect of community capacity on a population's health status and for the importance of supporting capacity-building initiatives as an adjunct to traditional health services programs.

Concepts: This report first demonstrates the use of geographical analysis of differences in health status, providing support from the research literature for links between regional disparities in a variety of health indicators and environmental conditions, cultural norms, and economic resources. The authors note that there are many paths health promotion can take, including improving environmental conditions, changing cultural norms, and strengthening the economy. Taking a wider view of the determinants of population well-being and methods of health promotion, the Trust advocates for the inclusion of community capacity-building initiatives in the repertoire of health promotion and disease prevention activities.

The Trust offers a definition of community capacity based on three principles:

- Individual and collective assets benefit the community as a whole, rather than specific individuals or organizations.
- Assets come from within the community itself, not from an external source.
- Collective use of individuals' assets creates "synergistic effects."

Based on their experience with capacity-building initiatives, the authors delineate five dimensions of community capacity:

Skills and knowledge, supported when necessary by the transfer of knowledge from outside "experts" to the community.

Leadership in both the forefront, catalyzing the community, and the background, mentoring and nurturing collaborative partners.

A sense of efficacy on both the individual and collective levels.

Trusting relationships, or "social capital," indicative of a sense of community, reciprocal relationships, and civic engagement.

A culture of openness and learning supporting divergent points of view.

The report provides recent empirical support linking elements of community capacity to health outcomes, including effects of social capital on mortality, neighborhood resources on low birthweight, and collective efficacy on violence.

Use: The report identifies some general strategies for using this conceptualization of community capacity to build the community's potential to promote its own health and well-being. Community empowerment initiatives, aimed at enhancing community assets rather than focusing on deficits, and provision of technical assistance in support of community-driven problem solving are offered as ways to bolster the indigenous strengths of the community from a grassroots perspective. In addition, promoting networking among community initiatives is suggested as an important means of fostering continuous capacity building among organizations.

Goodman RM, Wandersman A, Chinman M, Imm P, Morrissey E. An ecological assessment of community based interventions for prevention and health promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology* 1996; 24:33-61.

Overview: Goodman et al. address a problem inherent in many community health interventions to date, the use of individual-level indicators as the sole basis for evaluation of community-level projects. They propose instead the use of a social ecology approach, which goes beyond individual attitudes and behavior to target community-level factors such as community values and the comprehensiveness and coordination of services.

Concepts: An evaluation based on the ecological approach uses multiple sources and types of data and targets multiple social levels at different stages of community readiness (see Table 1). The community's readiness, in essence its "capacity to mobilize, structure, initiate, refine, and sustain an organized response" to a problem, affects the type of intervention activities that are appropriate at any point in time and is closely related to the developmental stages of coalitions. The use of varied data sources and methods, called triangulation, aids in the assessment of complex, multi-level phenomena.

Measurement: The authors describe the evaluation of a substance abuse prevention coalition tailored to the coalition's developmental stage, the stage of community readiness, and the ecological level involved:

Table 1: Evaluation Methods by Coalition Stages, Ecological Levels, and Stages of Readiness

Developmental Phases and Measures	Ecological Levels					Stages of Readiness
	Intrapersonal	Interpersonal	Organizational	Community	Public Policy	
Phase 1: Coalition Formation						Initial mobilization and establishing organizational structure
Forecast			X			
Meeting Effectiveness Inventory	X	X	X			
Project Insight Form	X	X	X			
Committee Survey	X	X	X			
Needs Assessment Checklist			X	X		
Plan Quality Index			X	X	X	
Phase 2: Plan Implementation						Building capacity for action and implementation
Tracking of Actions			X	X	X	
Prevention Plus III	X	X	X	X	X	
Policy Analysis Case Study			X		X	
Phase 3: Impact						Refining and institutionalizing
Key Leader Survey	X		X		X	
Community Survey	X			X		
Trend Data				X	X	
Level of Institutionalization Scale			X	X	X	

Source: Goodman et al., 1996.

The methods and instruments used are described below:

- Forecast System: Analysis of meeting minutes, phone logs, staff activity calendars, and resumes of coalition members; includes the Meeting Effectiveness Inventory (included in the article) and Project Insight Form for assessing the leadership, participation, decision-making, conflict resolution, and productivity of specific meetings
- Committee Survey: Analysis of group climate, member satisfaction, task orientation, leadership characteristics, staff support, membership costs and benefits, communication channels, linkages with community organizations, and conflict resolution
- Needs Assessment Checklist: Development of necessary steps for designing, implementing, and analyzing a needs assessment
- Plan Quality Index: Rates the action plan resulting from the needs assessment based on the specificity of goals and activities, time line, division of responsibilities, target groups, means of building community support, operational details, and potential barriers and solutions
- Tracking of Coalition Actions: Monthly logs monitoring community planning, community actions, community changes, collaboration, member recruitment, and resource generation
- Prevention Plus III: Four-step model identifying program goals, processes, outcomes, and impacts
- Policy Analysis Case Study: Assessment of the coalition's policy development strategies
- Key Leader Survey: Assessment of awareness, concern, and actions of community officials and administrators
- Community Survey: Assessment of impact on the individual level
- Trend Data: Analysis of archival data to indicate community-level trends before and after the intervention
- Level of Institutionalization Scale: Assessment of the sustainability of the program based on its imbeddedness in the host organization

Use: Important to this type of evaluation is the close interaction of evaluators with coalition members and staff. Its purpose is not only to assess the functioning and impact of the coalition, but to provide feedback to the coalition as a basis for improvement.

Wandersman A, Goodman RM, Butterfoss FD. Understanding coalitions and how they operate: An 'open systems' organizational framework. In Minkler M (ed.). *Community Organizing and Community Building for Health.* New Brunswick, NJ: Rutgers University Press, 1997, pp. 261-277.

Overview: In the proposed model, coalitions are viewed as organizations that are influenced by, and in turn influence, the environment. Four components of organizational functioning essential to coalition maintenance and effectiveness are presented.

Concepts: In an "open systems" model of organizational functioning, the coalition is a vehicle for translating resources from the environment into outputs affecting the environment. Sustaining the system requires four elements (see figure 1):

Resource Acquisition:

- member resources
  - size of membership
  - commitment to mission
  - personal and political efficacy
  - pooling of assets
- external resources
  - formalization of relationships
  - standardization of procedures
  - frequency of interactions and flow of resources
  - reciprocity
  - access to local communities
  - links to other organizations

Maintenance Subsystem:

- organization control
  - leadership structure
  - formalized rules, roles, procedures
  - decision-making and conflict resolution processes
- membership commitment and resource mobilization
  - volunteer-staff relationships
  - communication patterns
  - membership commitment and mobilization

Production Subsystem:

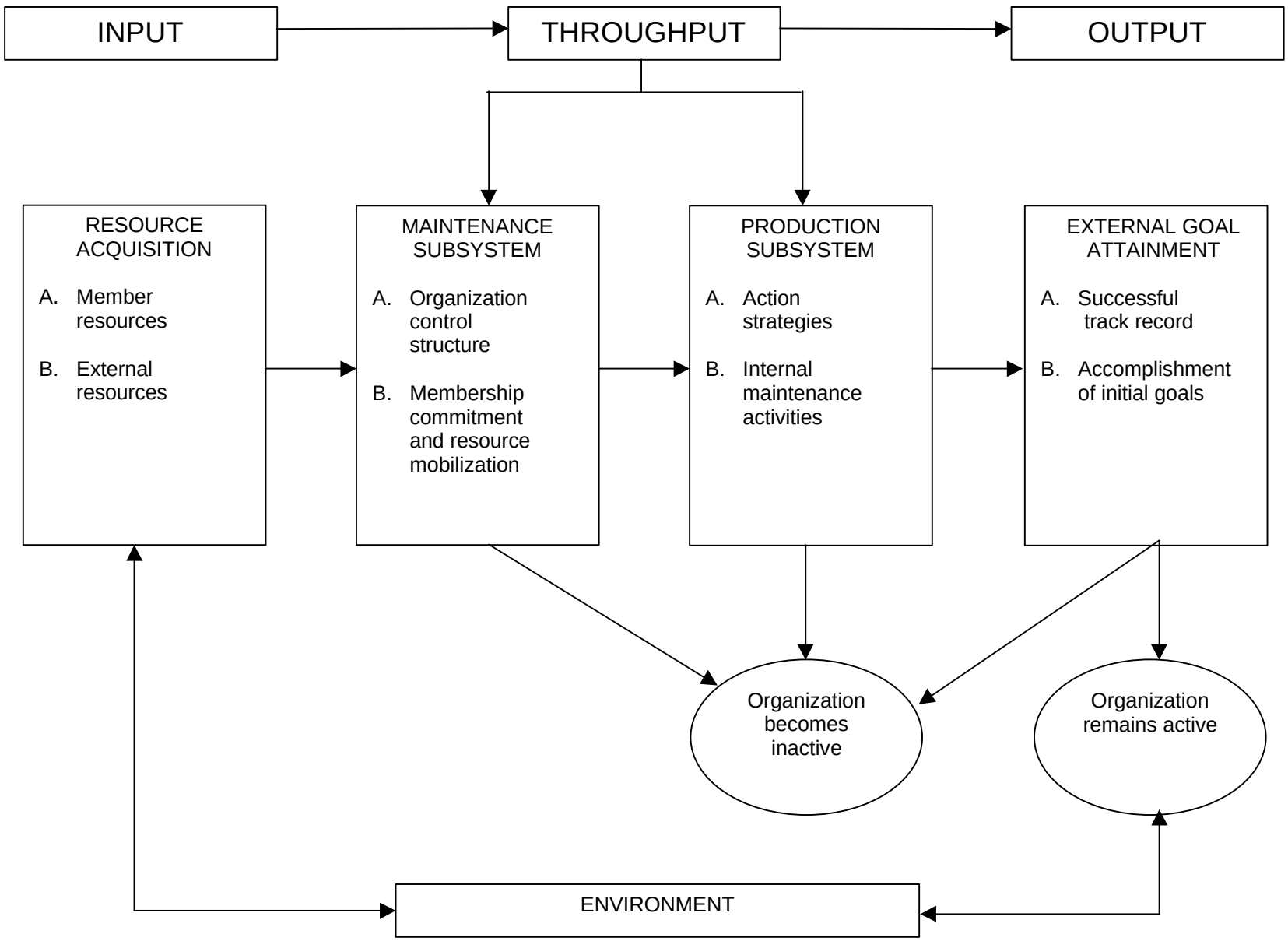
- goal-oriented activities
- maintenance activities

External Goal Attainment:

- short-term changes
- long-term changes

Use: The authors suggest that viewing coalitions as organizations dependent on these four elements will provide valuable insight into their functioning and viability.

Figure 1. Open Systems Framework



Source: Wandersman, Goodman, & Butterfoss, 1997.

The Aspen Institute, Rural Economic Policy Program. Measuring community capacity building: A workbook-in-progress for rural communities (version 3-96). The Aspen Institute, 1996.

Overview: This publication is premised on the importance of gauging the progress of citizens and community organizations in improving community life. Specific measures that can be used to document the outcomes of community capacity-building efforts are outlined in a concise workbook format.

Concepts: Community capacity, the collective ability to address community problems and strengthen community assets, is built on:

- *commitment* to act,
- *resources* (economic, human, etc.), and
- *skills* of individual community members and organizations.

Building community capacity is seen as a valuable end in its own right. Rather than viewing capacity building as an objective linked to the goals of a specific type of program, this guidebook frames community capacity building in an overall strategy for maintaining a healthy community. In the context of rural development, community capacity building is the springboard for sustainable economic development and stewardship of cultural and natural resources.

Measurement: The workbook is organized around outcomes, indicators, and measures. Eight outcomes of effective community capacity building are proposed:

- expanding, diverse, inclusive citizen participation;
- expanding leadership base;
- strengthened individual skills;
- widely shared understanding and vision;
- strategic community agenda;
- consistent, tangible progress toward goals;
- more effective community organizations and institutions; and
- better resource utilization by the community.

A section for each outcome includes indicators – measurable capacities for gauging achievement of outcomes (e.g., leadership infrastructure) – and sub-indicators (e.g., leadership development programs). Finally, for each indicator and sub-indicator, a number of actual measures are suggested, each identified by type (e.g., yes/no, percent, rating).

Uses: Although targeted to rural communities, this publication is applicable to other kinds of communities interested in documenting the effects of capacity-building efforts. Basic steps are provided to guide users in undertaking an assessment. Future versions of this workbook will include work pages for tracking the outcomes, indicators, and measures chosen for evaluation.

Fetterman DM, Kaftarian SJ, Wandersman A, eds. *Empowerment Evaluation: Knowledge and Tools for Self-Assessment and Accountability*. Thousand Oaks, CA: Sage Publications, 1996.

Overview: Empowerment evaluation fuses quantitative and qualitative methods in a process of program self-evaluation and improvement.

Concepts: In the introduction to this book, Fetterman describes the genesis of this approach and, in general terms, the steps it entails: 1) "taking stock," or assessment of program activities/components, strengths, and weaknesses; 2) setting goals that are linked directly to both program activities and outcomes; 3) developing strategies to reach objectives; and 4) documenting progress toward goals.

Some chapters in particular are notable for their emphasis on easily adaptable frameworks. Fawcett et al. describe an empowerment evaluation framework composed of four elements – agenda setting, strategic planning, implementation, and outcome – and provide examples of activities useful for each. The authors then develop these components and Fetterman's general evaluation process into six steps: 1) assessing community concerns and resources; 2) setting a mission and objectives; 3) developing strategies and action plans; 4) monitoring process and outcome; 5) communicating information to relevant audiences; and 6) promoting adaptation, renewal, and institutionalization. Yin, Kaftarian, and Jacobs translate the general empowerment evaluation model into an evaluation framework for community partnerships that includes collaboration across multiple levels, from the federal to the local, and emphasizes quality of the evaluation framework, implementation, and outcomes. Their framework encompasses eight sequential components: 1) partnership characteristics; 2) partnership capacity; 3) community actions and prevention activities; 4) immediate process and activity outcomes; 5) prevention program-related outcomes; 6) other community outcomes; 7) program impacts; and 8) contextual conditions.

Measurement: Part five of the book is of particular interest for readers interested in obtaining actual tools of the trade:

- Linney and Wandersman present Prevention Plus III, a tool developed for use by nonprofessional evaluators of community prevention programs. Sample worksheets from each of the four steps of the model (goal and outcomes identification, process assessment, outcome assessment, and impact assessment) are included.

- Dugan describes the development of a participatory and empowerment evaluation framework encompassing five stages: organizing for action, building capacity for action, taking action, refining the action, and institutionalizing the action. For each stage, participant tasks, evaluator tasks, and a percentile breakdown of the evaluator's roles (e.g., facilitator, mentor) are presented. Sample worksheets adapted from Prevention Plus III are provided.

- Butterfoss et al. introduce the Plan Quality Index, a tool for assessing coalition plans and channeling information back to coalition members for use in program improvement. The instrument, included in an appendix in its entirety, assesses the adequacy of the plan's components and scope, the necessary community resources, and overall impression of the plan.

- Mayer proposes an evaluation approach that is consistent with the principles of community capacity building, providing examples of evaluation techniques that promote a constructive environment, inclusivity, and advocacy.

Use: What differentiates this method from other assessment processes is its basis in empowerment theory and its focus on self-determination; the role of the professional evaluator in empowerment evaluation is to train, facilitate, even to advocate, all with the goal of fostering self-sufficiency of the program in evaluation and monitoring. The methodological concerns that might be raised about the use of empowerment evaluation, including scientific rigor, intersection with traditional evaluation methods, objectivity, participant bias, and validity are addressed in the introduction and other chapters. Many of the chapters present examples of empowerment evaluation in practice, but with a focus on conceptual and methodological issues that are relevant to program types other than those presented as well.

McKnight JL, Kretzmann JP. *Mapping Community Capacity*. Evanston, IL: Institute for Policy Research, Northwestern University, 1990.

Overview: McKnight and Kretzmann propose a capacity-oriented approach to community building that is radically different from the traditional needs assessment approach to community-based initiatives.

Concepts: McKnight and Kretzmann write from a community development perspective that views the capabilities and resources indigenous to a community as the foundation for sustainable urban renewal efforts led by community residents. Conversely, they argue, the traditional human services approach unnecessarily conditions whole communities to become dependent on outside resources.

Measurement: The Neighborhood Assets Map is built on three categories of assets and capacities:

- *Primary building blocks* indicate assets and capacities that are located within neighborhoods and controlled by residents. They are made up of individual skills and assets as well as organizational assets.
- *Secondary building blocks* indicate assets and capacities that are located in the neighborhood but controlled by outsiders. These include private and non-profit organizations, public institutions, and physical resources such as vacant structures that can be redeveloped.
- *Potential building blocks* indicate assets and capacities that are both located outside of the neighborhood and controlled by outsiders. They include public assets such as welfare expenditures, capital improvement funding, and public data.

Use: The assets map lays the groundwork for the creation of an Asset Development Organization, using existing community organizations, community development corporations, or citizens associations. This group undertakes a community planning process, mobilizing representatives of the neighborhood assets identified in the map. This process includes some form of inventory of neighborhood capacity. A tool for collecting data on capacities of individual residents is included in the document. As a final step, the Asset Development Organization begins to form connections with outside entities and activities.

Internet Resources for Community Building Concepts and Methods

If "www" is either optional or required for access to a website listed below, it is included in the address provided. The absence of "www" indicates that its use interferes with access to the site.

AHEC/Community Partners ***www.ahecpartners.org***

AHEC/Community Partners is a non-profit coalition building and community capacity development institute serving Massachusetts. Part of the Massachusetts Area Health Education Center system, the institute is based in the University of Massachusetts Medical School. The website offers downloadable publications on topics such as coalition development, planning and evaluation, community assessment, and community involvement.

The Asset-Based Community Development Institute ***www.nwu.edu/IPR/abcd.html***

The Asset-Based Community Development Institute, part of Northwestern University's Institute for Policy Research, is the focal point for dissemination of information related to McKnight and Kretzmann's work on building community capacity. This site includes access to a variety of tools for use in capacity-building initiatives (e.g. capacity inventory, training manual) and publications on related topics, many of them downloadable. The site also includes access to an e-mail discussion group for people working in community-building activities.

Amherst H. Wilder Foundation ***www.wilder.org***

Although this foundation provides local health and human services programs in St. Paul, Minnesota, its website offers publications of national interest on community development, strengthening urban communities, and non-profit management.

Civic Practices Network ***www.cpn.org***

This multi-disciplinary network is a locus for information related to the "new citizenship movement," which is premised on the need for communities to reassert responsibility for public, collaborative problem solving. Essays and guides addressing community responsibility and community building (e.g., social capital, community organizing, asset-based community development) are posted.

COMM-ORG ***comm-org.utoledo.edu***

COMM-ORG, the On-Line Conference on Community Organizing and Development, provides several interactive forums, including a series of working papers posted for reader review and an e-mail discussion list. The site also directs users to a large number of websites related to community organizing and development. These links are categorized as: community organizing groups and networks; community organizing training and technical assistance; community organizing funding; community organizing and development readings; course syllabi; policy links; research databases; action research resources; resources for public health community organizing and development; community-based planning resources; community-based development resources; information on effective use of the internet in activism; and multimedia related to social change.

Community Building Institute ***www.xu.edu/cbi***

Based in Cincinnati, Ohio, this cooperative venture of Xavier University and United Way & Community Chest focuses on asset-based community development. The website provides access to training and technical assistance as well as links to other community building organizations and publications.

Community Building Resources ***www.cbr-aimhigh.com***

This Canadian company provides technical assistance in asset-based community capacity building and community assets mapping. The CBR internet site summarizes its Community Capacity Building and Asset Mapping© model and related projects. A list of references on community development is also posted.

Community Development Society ***www.comm-dev.org***

The Community Development Society is an international, multi-disciplinary professional association that focuses on community capacity building with an emphasis on citizen participation. The website includes links to other community development internet resources.

Community Toolbox ***ctb.lsi.ukans.edu***

The Community Toolbox is a vital resource for people engaged in community-based initiatives. Developed by the University of Kansas Work Group on Health Promotion and Community Development and AHEC/Community Partners, this site offers extensive guides to a wide variety of activities essential to effective community capacity building: grant writing; advocacy and public education; recruitment of members; strategic planning; organizational development; leadership development; community assessment; implementation; collaboration; monitoring and evaluation; and institutionalization. These training materials can be navigated through several routes. A "Guide for Community Problem Solving" links community problems faced by the user to relevant sections. The training materials can also be accessed through links built into two models of community change, "Building Community Capacity for Change" and the "Community Health Improvement Process (CHIP)." The site's "General Store" provides access to publications and fee-based technical assistance.

Institute of Health Promotion Research *www.ihpr.ubc.ca/guidelines.html.*

This institute, part of the University of British Columbia, is dedicated to linking multi-disciplinary research and community health promotion practice. Of particular interest on the IHPR's website are the *Guidelines And Categories For Classifying Participatory Research Projects In Health Promotion* (see Annotated Bibliography) and its reports on surveys of Community Participation in Health System Decision Making in Canada.

National Civic League ***www.ncl.org***

The National Civic League works to enhance collaborative, community-driven problem solving through three programs accessible from its website. Its Community Assistance Team offers technical assistance in designing and implementing community-based initiatives. The Healthy Communities Program involves identification of key community stakeholders, development of a community vision for the future, assessment and evaluation tools (e.g., The Civic Index for measuring community resources, benchmarking, asset mapping), and skills for effective leadership and organizational interaction. The Program for Community Problem Solving conducts research and offers technical assistance in developing communities' capacity for collaborative activities. The site lists publications from all NCL programs, including guides and instruments for use in collaborative and community-based activities.

National Community Building Network ***www.ncbn.org***

This membership organization brings together urban poverty reduction/community building projects for networking and mutual learning. Its website offers information about community building principles, events and conferences related to community building, news about policies impacting urban rebuilding efforts, a directory of resources (organizations, reference lists, and website links), and a downloadable version of the Network's newsletter.