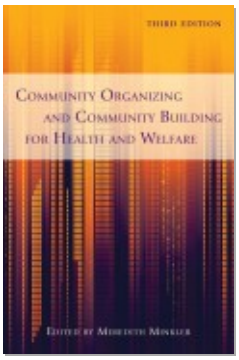
Community Organizing and Community Building for Health and Welfare



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17

A Coalition Model for Community Action

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The development of community coalitions has escalated rapidly over the past thirty years. Thousands of coalitions anchored by government or community-based organizations have been created to support community-based, health-related activities across the United States. For example, coalitions of health-related agencies, schools, and community-based action groups have formed to prevent tobacco use and promote healthy weight and physical activity among youth. Advocates for environmental issues, such as asthma and lead contamination, have rallied to highlight their issue or promote favorable policy and legislation. Civic and faith-based groups have developed coalitions to ensure adequate housing for the elderly and health insurance for low-income populations. Coalitions develop when different sectors of the community, state, or nation join together to create opportunities that will benefit all their partners in achieving mutual goals. The best of these coalitions have been vehicles to bring people together, expand available resources, focus on a problem of community concern, and achieve results better than those that any single group or agency could have achieved alone.

Coalitions, however, are not a panacea. Although they are usually built from unselfish motives to improve communities, coalitions still may experience difficulties that are common to many types of organizations, as well as some that are unique to collaborative efforts (Dowling et al. 2000; Wolff 2010). With the initiation of a coalition, frustrations can arise. Promised resources may not be made available, conflicting interests may prevent the coalition from having its desired effect in the community, and recognition for accomplishments may be slow in coming. Because it involves a long-term investment of time and resources, a coalition should not be built if a simpler, less complex structure will get the job done or if the community does not embrace this approach.

Coalitions are now commonplace in community-based efforts to improve health. Clearly, communities are committed to the *practice* of building coalitions.

However, it is equally important to forge and refine a comprehensive *theory* of community coalitions. The community coalition action theory, complete with constructs and propositions, has been developed to increase our understanding of how community coalitions work in practice (Butterfoss and Kegler 2009). Before this model is presented in detail here, its underpinnings will be highlighted, beginning with the rationale for collaboration.

Collaboration

Collaboration begins when a perceived need exists and two or more organizations anticipate deriving a benefit that depends on mutual action (Gray 2000). Collaboration is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals" (Mattesich et al. 2001, 7). These organizations often enter into a formal, sustained commitment to mutual relationships/goals; jointly developed structures; shared responsibility; mutual authority/accountability; and shared resources/rewards.

Collaboration represents the highest level of working relationships that organizations can experience. Collaboration changes the way organizations work together—it moves them from competing to building consensus; from working alone to including others from diverse cultures, fields, and settings; from thinking mostly about activities, services, and programs to looking for complex, integrated strategies; and from focusing on short-term accomplishments to broad policy, systems, and environmental changes (Butterfoss 2007).

Despite their rewards, effective collaborations must acknowledge and respect each organization's self-interest (i.e., structure, agenda, values, and culture), relationships, linkages, and how power is shared and distributed (Gray 2000). Three types of working relationships build on each other and may lead to collaboration: networking, cooperation, and coordination. These relationships exist across a continuum in which (1) linkages become more intense and are influenced by common goals, tasks, rules, and resources; (2) purposes become more complex as information sharing gives way to joint problem solving; (3) agreements become more formal, with operating procedures and policies; and (4) relationships take more time to develop and involve greater risks and rewards (Himmelman 2001).

Coalitions: Effective Vehicles for Collaboration

Coalitions are formal, long-term collaborations that are composed of diverse organizations, factions, or constituencies that agree to work together to achieve a common goal (Feighery and Rogers 1990). A coalition is action oriented and focuses on reducing or preventing a community problem by analyzing the issue, identifying and implementing solutions, and creating social change (Butterfoss et al. 1993; Butterfoss and Kegler 2002). The best coalitions bring people together, expand resources, focus on issues of community concern, and achieve better

results than any single group could achieve alone (Butterfoss and Kegler 2002). Technically, partnerships assume a more businesslike arrangement and may involve as few as two partners, but the terms *coalitions* and *partnerships* are used interchangeably. Coalition members may be individuals, organizations, or groups. However, if a coalition is composed solely of individuals, then it should be classified as an organization or network. Membership size may vary, but a coalition usually involves both professional and grassroots organizations.

Coalitions are one of the most effective strategies for achieving community change. Through advocacy and education, coalitions are critical for mobilizing communities to develop and implement effective strategies and policies for the following reasons (CDC 2008):

1. Coalitions are versatile—they have been used effectively in all states; in thousands of cities, towns, and counties across the United States; and in many other countries.
2. Science supports coalitions as an effective approach for changing social norms and policies that lead to decreased morbidity and mortality (Crowley et al. 2000; National Cancer Institute 2005; Roussos and Fawcett 2000).
3. While the financial investment in coalitions is relatively low, they effectively leverage resources (e.g., members' services, time, and expertise) that enhance public health outcomes.
4. Coalitions enhance the stability of public health programs by building political/public support, securing/maintaining funding, and advocating for policy change.

Types of Coalitions

Coalitions may be categorized by their patterns of formation, functions, or structures that accommodate these functions. However, most are typed according to membership or geographic focus. Three types of coalitions are based on *membership* (Feighery and Rogers 1990):

- *Grassroots coalitions* are organized by advocates in times of crisis to pressure policymakers to act on an issue. They can be controversial, but effective, in reaching their goals and often disband when the crisis ends, such as when a group of residents pressures county officials to pass a smoke-free public places ordinance.
- *Professional coalitions* are formed by professional organizations or agencies to increase their power and influence, such as when health professionals pressure their state licensing board to establish more group homes for mental health patients. Although funding is provided to address community issues, the strategies usually come from professionals or institutions; local residents are secondary players (Wolff 2010).

- *Community coalitions* of professional and grassroots members are formed to influence more long-term health and welfare practices for their community, such as obesity prevention coalitions (see chapter 18). Community ownership is higher in these groups, but external funding is often required to provide needed resources.

Coalitions may also be classified by their *geography*—they may focus on community, regional, state, national, or international levels. *Community coalitions* operate in neighborhoods, towns, cities, or counties and usually serve a defined location that is recognized by local residents as representing and serving them (Clarke et al. 2006). Its members reflect the diversity and wisdom of that community, at both grassroots and "grasstops" (professional) levels (Butterfoss et al. 1993). These members have direct experience with the social/health problem of interest and are actively engaged in decision making and problem solving.

State coalitions develop to facilitate communication and develop strategies over larger geographic areas. Effective state coalitions immediately forge relationships with community coalitions or do so when they recognize the need to disseminate information and strategies widely. Likewise, community coalitions mobilize to form state coalitions when they realize the benefits of more widespread commitment and support for their issue, for example, statewide health care access (see chapter 21). Both approaches work well—the key is to link local and state concerns and resources. Many community coalitions are funded through state-level public health initiatives that have statewide coalitions.

Benefits of Community Coalitions

Coalitions and other collaborative efforts in public health offer many direct and indirect benefits (Butterfoss 2007), such as the following:

- Serving as effective and efficient vehicles for exchanging knowledge and ideas
- Demonstrating and developing community buy-in or concern for issues
- Establishing greater credibility, trust, and communication among community agencies and sectors
- Mobilizing diverse populations, talents, resources, and strategies
- Sharing costs and associated risks
- Leveraging resources to minimize duplication of efforts and services
- Negotiating potential conflict by sharing power
- Reducing the social acceptability of health risk behaviors
- Advocating for policy change by enlisting political and constituent support
- Developing synergy that allows organizations to adopt new issues without having sole responsibility for them

When real community involvement exists, coalitions address community health concerns while empowering or developing capacity in those communities.

Coalition membership may lead to increased community participation and leadership, skills, resources, social/ interorganizational networks, sense of community, community power, and successful community problem solving (Kegler et al. 2007).

The overarching benefits that coalitions provide are improved trust and communication among agencies and organizations, as evidenced by increased networking; information sharing; and access to ideas, materials, and resources. This may help coalitions to more effectively engage their priority populations. In turn, community members are more likely to support and use public programs/services when they have input into setting priorities and tailoring programs/services to local needs and services. Open and transparent communication that is facilitated through community coalitions also may increase public awareness of relevant policy/legislative issues and provide better evaluation of the impact of coalition strategies (Jackson and Maddy 2001).

Coalitions are best suited to assessing community assets and needs, enacting strategic/action planning, conducting social marketing campaigns, implementing policy and environmental change strategies, educating community members and policymakers, providing technical assistance or training, garnering financial and in-kind resources, and enhancing community buy-in and involvement. Coalitions should focus on promising or evidence-based strategies that are more likely to be effective and less on one-on-one education and costly programs or services that compete with those offered by their members.

Although coalitions are used in health promotion and disease prevention efforts of every kind, the most effective coalition examples exist in tobacco control and prevention's nearly forty-year history of educating communities about the negative health effects of tobacco use and secondhand smoke exposure and advocating for evidence-based policy strategies. This has led to decreased tobacco consumption, prevention of initiating tobacco use, and decreased tobacco-related disease and mortality. Tobacco control coalitions have (National Cancer Institute 2005) effected the following:

- Advocated for increased tobacco excise taxes at state and local levels
- Reduced and eliminated tobacco product advertising and promotion
- Established countermarketing campaigns to disseminate anti-tobacco media messages promoting the adoption of healthy behaviors and to provide information on health risks
- Decreased social acceptability of tobacco by educating diverse groups (e.g., faith based, low income, youth) to further relay messages and create social norm change
- Expanded smoke-free environments in work/public places and taken action in preemption states
- Limited availability of and access to tobacco products, particularly to persons under eighteen years old

To summarize, coalitions are excellent vehicles for consensus building and active involvement of diverse organizations and constituencies in addressing community problems. They enable communities to build capacity and to intervene using a social-ecological approach. By involving community members, coalitions help to ensure that interventions meet the needs of the community and are culturally sensitive. Community participation through coalitions also facilitates ownership, which, in turn, is thought to increase the chances of successful institutionalization into the community (Butterfoss 2007). These advantages of community coalition approaches are widely accepted by government agencies and foundations, and, as a result, the majority of prevention initiatives over the past two decades have required the formation of community coalitions as a condition of funding. The next section describes the theory, constructs, and assumptions developed to further our understanding of community coalitions.

Community Coalition Action Theory

Although clear theoretical underpinnings have always existed for community coalitions, until the past decade, the practice of coalition building outpaced the development of coalition theory. Once viewed as atheoretical with an insufficient conceptual and empirical base, the literature now is rich with case studies, evaluation/research findings, and conceptual frameworks to explain coalition functioning and how they are instrumental in creating community change. The community coalition action theory (CCAT) attempts to synthesize and provide an overarching framework for what is known about coalitions both empirically and from years of collective experiences (Butterfoss and Kegler 2009). The theoretical underpinnings of CCAT, which is articulated in "practice-proven propositions," stem from prior work in community development, participation and empowerment, interorganizational relationships, and social capital (Butterfoss and Kegler 2002).

The field of community development and related work in citizen participation articulates the underlying philosophy for community-driven approaches—that people deserve a voice in designing changes that affect or take place in their communities, that communities have the capacity to address their own problems, and that resident involvement and ownership in community change leads to greater sustainability (see chapter 1). Individual, organizational, and community empowerment are essential to participatory approaches, such as coalition-based initiatives, that build community capacity for change (Chávez et al. 2010; Wendel et al. 2009; see chapters 1 and 3).

Coalition theory also draws from interorganizational relations research to explain why organizations enter collaborative relationships (e.g., to acquire resources and reduce uncertainty), the stages of collaboration, and how benefits must outweigh costs to ensure continued participation (Butterfoss et al. 2008). Social capital, described as the trust, networks, and norms of reciprocity that

enable people to effectively work together, includes two operational levels (Putnam 2000; Kawachi et al. 2008; Kreuter and Lezin 2002). CCAT recognizes both implicitly: *bonding social capital* creates group cohesion and a sense of belonging, which may result from a coalition's positive organizational climate. *Bridging social capital* refers to factors that facilitate the linking of organizations within a community, as well as connections to resources external to the community (Kreuter and Lezin 2002).

CCAT has been described in detail elsewhere (Butterfoss and Kegler 2002, 2009); the definitions of constructs are listed in Table 17.1 and propositions of constructs in Table 17.2. According to the model illustrated in Figure 17.1, coalitions progress through stages from formation to institutionalization, with frequent loops back to earlier stages as new issues arise or as planning cycles are repeated (propositions 1 and 2). Researchers have presented various series of stages and specific tasks that should be accomplished for each (Butterfoss and Kegler 2009); however, we suggest three stages: formation, maintenance, and institutionalization. To illustrate the overlapping nature of tasks that must be achieved during maintenance and implementation, they have been combined and represented in Figure 17.1 as *maintenance*. Contextual factors of the community, such as the sociopolitical climate, norms, geography, and history that surround collaborative efforts, affect each stage (proposition 3).

In the *formation stage*, a convener or lead agency with given strengths and linkages to the community brings together core organizations that recruit an

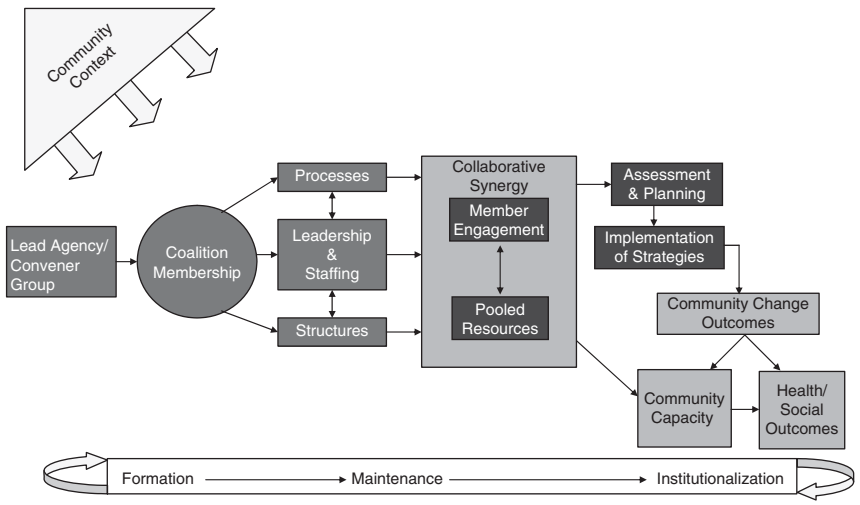

FIGURE 17.1 Community Coalition Action Theory (CCAT). From F. D. Butterfoss, "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory," in *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 236–276, 2nd ed. (San Francisco: Jossey-Bass, 2009).

TABLE 17.1.

Constructs and Definitions, Community Coalition Action Theory

Construct	*Definition*
Stages of development	The specific stages or phases that a coalition progresses through from formation to implementation to maintenance to institutionalization. Coalitions may recycle through stages more than once or as new members are recruited, plans are renewed, or new issues are added.
Community context	The specific factors in the community that may enhance or inhibit coalition function and influence how the coalition moves through its stages of development. These factors include history of collaboration, politics, social capital, trust between community sectors and organizations, geography, and community readiness.
Lead agency/ convener group	The organization that responds to an opportunity, threat, or mandate by agreeing to convene the coalition; provides technical assistance or financial or material support; lends its credibility and reputation to the coalition; and provides valuable networks/ contacts.
Coalition membership	The core group of people who represent diverse interest groups, agencies, organizations, and institutions and are committed to resolving a health or social issue by becoming coalition members.
Processes	The means by which business is conducted in the coalition setting by developing clear processes that facilitate staff and member communication, problem solving, decision making, conflict management, orientation, training, planning, evaluation, and resource allocation. These processes help create a positive organizational climate in which the benefits of participation outweigh the costs.
Leadership and staffing	The volunteer leaders and paid staff with the interpersonal and organizational skills to facilitate the collaborative process and improve coalition functioning.
Structures	The formalized organizational arrangement, rules, roles, and procedures that are developed in a coalition to maximize its effectiveness. These include vision and mission statements, goals and objectives, an organizational chart, steering committee and work groups, job descriptions, meeting schedules, and communication channels.

(*continued*)

TABLE 17.1. Constructs and Definitions, Community Coalition Action Theory (*continued*)

Construct	*Definition*
Pooled member and external resources	The resources that are contributed or elicited as in-kind contributions, grants, donations, fund-raisers, or dues from member organizations or external sources that ensure effective coalition assessment, planning, and implementation of strategies.
Member engagement	The satisfaction, commitment, and participation of members in the work of the coalition.
Collaborative synergy	The mechanism through which coalitions gain a collaborative advantage through engagement of diverse members and pooling of member, community, and external resources.
Assessment and planning	The comprehensive assessment and planning activities that make successful implementation of effective strategies more likely.
Implementation of strategies	The strategic actions that a coalition implements across multiple ecological levels that make changes in community policies, practices, and environments more likely.
Community change outcomes	The measurable changes in community policies, practices, and environments that may increase community capacity and improve health or social outcomes.
Health/social outcomes	The measurable changes in health status and social conditions of a community that are the ultimate indicators of coalition effectiveness.
Community capacity	The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems. Participation in a coalition may enhance these characteristics, which include citizen participation and leadership, resources, skills, social and interorganizational networks, sense of community, and power.

From F. D. Butterfoss, "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory," in *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 236–276, 2nd ed. (San Francisco: Jossey-Bass, 2009). Reprinted with permission.

TABLE 17.2.

Constructs and Related Propositions, Community Coalition Action Theory

Construct	*Proposition*
Stages of development	1. Coalitions develop in specific stages and recycle through these stages as new members are recruited, plans are renewed, and/or new issues are added.
	2. At each stage, specific factors enhance coalition function and progression to the next stage.
Community context	3. Coalitions are heavily influenced by contextual factors in the community throughout all stages of development.
Lead agency/ convener group	4. Coalitions form when a lead agency/convener responds to an opportunity, threat, or mandate.
	5. Coalition formation is more likely when the lead agency/convener provides technical assistance, financial or material support, credibility, and valuable networks/contacts.
	6. Coalition formation is likely to be more successful when the lead agency/convener enlists community gatekeepers to help develop credibility and trust with others in the community.
Coalition membership	7. Coalition formation usually begins by recruiting a core group of people who are committed to resolving the health or social issue.
	8. More effective coalitions result when the core group expands to include a broad constituency of participants who represent diverse interest groups and organizations.
Processes	9. Open and frequent communication among staff and members helps make collaborative synergy more likely through member engagement and pooling of resources.
	10. Shared and formalized decision making helps make collaborative synergy more likely through member engagement and pooling of resources.
	11. Conflict management helps make collaborative synergy more likely through member engagement and pooling of resources.
Leadership and staffing	12. Strong leadership from a team of staff and members improves coalition functioning and makes collaborative synergy more likely through member engagement and pooling of resources.

(*continued*)

TABLE 17.2. Constructs and Related Propositions, Community Coalition Action Theory (*continued*)

Construct	*Proposition*
	Paid staff make collaborative synergy more likely through member engagement and pooling of resources.
Structures	13. Formalized rules, roles, structures, and procedures improve collaborative functioning and make collaborative synergy more likely through member engagement and pooling of resources.
Member engagement	14. Satisfied and committed members will participate more fully in the work of the coalition.
Pooled member and external resources	15. The synergistic pooling of member and external resources prompts comprehensive assessment, planning, and implementation of strategies.
Assessment and planning	16. Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur.
Implementation of strategies	17. Coalitions are more likely to create change in community policies, practices, and environments when they direct interventions at multiple levels.
Community change outcomes	18. Coalitions that are able to change community environments, policies, and practices are more likely to increase capacity and improve health/social outcomes.
Health/social outcomes	19. The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.
Community capacity	20. By participating in successful coalitions, community members/organizations develop capacity and build social capital that can be applied to other health and social issues.

From F. D. Butterfoss, "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory," in *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 236–276, 2nd ed. (San Francisco: Jossey-Bass, 2009). Reprinted with permission.

initial group of community partners to initiate a coalition effort focusing on a health or social issue of concern (propositions 4–8). The coalition identifies key leaders and staff, who then develop structures (for example, committees and rules) and operating procedures (processes) that promote coalition effectiveness. Structural and process elements in the coalition (propositions 9–14) can help to ensure a positive organizational climate, an engaged coalition membership,

and the pooling of member and external resources. This stage also requires balancing benefits associated with membership to ensure they outweigh any costs of participation.

The *maintenance stage* involves sustaining member involvement and creating collaborative synergy (proposition 15). Success in this stage also depends on the mobilization and pooling of member and external resources (proposition 16). The coalition relies on resources from members and external sources to design creative and comprehensive strategies or to identify and adapt evidence-based interventions that are appropriate for the local context and have the greatest chance of leading to the desired health or social outcomes. Acquisition of resources, combined with engaged coalition members and a comprehensive and multilevel planning and implementation process, lead to changes in community policies, practices, and environments (propositions 17 and 18).

The maintenance stage also includes implementation of multilevel strategies of sufficient duration and intensity to have an effect. If these strategies are effective, shorter-term outcomes occur, such as changes in individual knowledge, beliefs, self-efficacy, and behavior, as well as transitional changes in community systems, policies, practices, and environments (proposition 19). These intermediate changes should lead to long-term outcomes, such as reductions in morbidity and mortality or substantive progress toward other social goals (proposition 20).

Finally, in the *institutionalization stage*, successful strategies lead to outcomes. If resources have been adequately mobilized and strategies effectively address an ongoing need, coalition strategies may become institutionalized as part of a long-term coalition or may be adopted by other community organizations. The coalition itself may or may not be institutionalized in a community. Both maintenance and institutionalization stages have the potential to increase community capacity to solve problems. Progress in ameliorating one community problem can potentially increase the capacity of local organizations to apply these skills and resources to address additional issues that resonate with the community (proposition 21). The rest of this chapter will describe these stages in more detail to highlight their common issues and challenges.

Coalition Formation

Coalitions typically form when a lead agency or convener group responds to an opportunity, such as new funding; a threat, such as the closing of a rural hospital; or a mandate from higher levels of administration, such as state or federal government for local agencies or regional or national headquarters for other types of organizations. Community-based organizations, health departments or other local government units, or educational institutions or local hospitals may serve as conveners, depending on the particular project and its required financial accountability systems. The lead agency initiates coalition formation by recruiting a core group of community leaders and providing initial support for the coalition.

Some community groups may not have 501c(3) status and, therefore, have difficulties accepting grant funds, which often support coalition formation. One model that has worked in some smaller communities is for a regional organization to serve as the fiscal sponsor, while another more local organization takes responsibility for coalition building and strategic aspects of an initiative.

Research on coalitions suggests that coalitions often evolve from other, preexisting coalitions and networks (Butterfoss et al. 2006), which may accelerate their development. On the other hand, new initiatives can inherit past agendas, old ways of thinking, and grievances and conflicts that may limit coalition effectiveness (Kadushin et al. 2005). Composition of the core group affects its ability to engage a broad spectrum of the community (Kegler et al. 2010). Communities are often divided, sometimes by social class or race/ethnicity; values and ideology; or features of the geography, such as waterways that congest bridges, tunnels, and roads. According to CCAT, the core group must recruit those committed to the prioritized issue and a broad constituency of diverse groups and organizations, including community gatekeepers. This pooling of diverse views, perspectives, and resources is the hallmark of a coalition approach and enables them to address problems in ways that a single agency could not achieve on its own. Effective coalitions are deliberate in recruiting diverse members with specific expertise, constituencies, perspectives, backgrounds, and sectors.

Another important task in the formation stage of coalition development is the selection of staff and leadership. Effective coalition leadership requires a collection of qualities and skills that are typically not found in one individual, but rather in a team of committed leaders. Coalitions are labor intensive in terms of cultivating and maintaining relationships and ensuring smooth and efficient group processes. Insufficient or poor leadership can lead to coalition failure through endless meetings with no real substance or infrequent meetings with no progress between meetings. Empirical research on coalitions shows a consistent relationship between leader competence and member satisfaction. Research also demonstrates relationships between staff competence and member satisfaction, member benefits, participation, action plan quality, resource mobilization, implementation of planned activities, and perceived accomplishments (Kegler et al. 2005; Florin et al. 2000).

Coalition leaders and staff organize the structures through which coalitions accomplish their work and are responsible for coalition processes, such as communication and decision making that keep members satisfied and committed to coalition efforts. Practically speaking, coalitions accomplish much of their day-to-day work in small groups. Therefore, managing group processes, such as decision making, communication, and conflict management, is critical (Kegler et al. 2005; Butterfoss et al. 2006; Florin et al. 2000).

CCAT asserts that more formal coalitions are better able to engage members, pool resources, and assess and plan well. Formalization is the degree to which rules, roles, and procedures are precisely defined. Examples of formal structures

include committees, written memoranda of understanding, bylaws, policy and procedures manuals; clearly defined roles; mission statements, goals, and objectives; and regular reorientation to the mission, goals, roles, and procedures of collaboration (Butterfoss 2007). Formal structures often result in the routinization or persistent implementation of the partnership's operations. The more routinized operations become, the more likely it is that they will be sustained. Some coalitions, especially those with a high proportion of grassroots residents, may resist formalization, viewing it as inconsistent with local culture. The external trappings of formalization may not be essential (e.g., bylaws or Robert's Rules of Order), but the underlying advantages of clarity of mission, continuity between meetings, and transparent processes usually are essential to success.

Coalition Maintenance and Implementation

Following coalition formation, coalitions must plan, select, and implement actions to address their priority issues. At this point in a coalition's life cycle, members have been recruited, structures and processes are in place, and, ideally, members are enthused about their upcoming collaborative work. Members are the lifeblood of a coalition—they set its vision, course, and outcomes and represent the authentic voices of the community. Capable coalition members are sought after, recruited, trained, and valued. Member engagement is best defined as the process by which members are empowered and develop a sense of belonging to the coalition (Butterfoss and Kegler 2009). Positive engagement is evidenced by commitment to the mission and goals of the coalition, high levels of participation both in and outside of coalition meetings and activities, and satisfaction with the work of the coalition (Butterfoss and Kegler 2009). Engaging members over time is more likely when the benefits of membership outweigh the costs and when members experience a positive coalition environment (Butterfoss 2007).

To foster member engagement, coalitions should review their roster annually and ask for letters of commitment. However, members often participate in coalitions with varying levels of intensity—they may be core members who assume leadership roles or those who seek networking opportunities. Members rarely stay active throughout the coalition's life and may experience burnout if they do. Having different categories of membership provides flexibility that allows members to move into/out of activities depending on competing loyalties or demands from home or work. Categories of members for community coalitions include the following (Butterfoss 2007):

- *Active members*—involved in the work of the coalition, attend most meetings/events, serve on work groups, assume leadership roles, recruit members, and help fund-raise.
- *Less active members*—lend their name and credibility to coalition efforts, publicly promote its work, and provide valuable connections to key organizations or populations, even if they only attend occasional coalition meetings or

events. These members include community leaders, administrators, school officials, politicians, and religious leaders.

- *Inactive members*—networkers or those who want to stay informed and receive mailings, but rarely attend meetings. They may be asked to do specific tasks or become active later.
- *Shared members*—more than one individual is selected by their organization to alternately attend meetings and share responsibilities. The downside of this arrangement is that valuable time is spent in "catching members up" and they often are unprepared to make decisions.

Coalition maintenance also entails the ongoing pooling of resources and mobilization of talents and diverse approaches to problem solving. When human and material resources are relatively scarce, collaboration is a necessary and logical strategy for addressing community problems, such as health disparities. Disparities and inequities in health have multiple causes and consequences that require complex solutions from multiple disciplines and organizations. In some communities, health and human services organizations are limited in addressing such issues because of fragmented services and unequal access to resources. By sharing their human and material resources, finances, and time, coalitions provide a multifaceted approach that can reverse the declining trend in civic engagement and reengage organizations to address local problems (Wolff 2010).

Members are a coalition's greatest asset—they bring energy, knowledge, skills, expertise, perspectives, connections, and tangible resources to the table. The power to combine the perspectives, resources, and skills of a group of individuals and organizations has been termed *synergy* (Lasker et al. 2001). This pooling of resources ensures more effective assessment, planning, and implementation of comprehensive strategies that give coalitions unique advantages over less collaborative problem solving approaches (Lasker et al. 2001). Both internal and external partners can provide meeting facilities, mailing lists, referrals, loans or donations, equipment, supplies, and cosponsorship of events (Braithwaite et al. 2000).

Effective coalitions have leaders who promote productive interactions among diverse members and who make good use of their participants' in-kind resources, financial resources, and time (Lasker et al. 2001). High levels of synergy that result from collaborative administration and management enhance the ability of coalitions to obtain sufficient nonfinancial resources from their participants (e.g., skills, information, connections, and endorsements). In short, the synergy that is created from collaborative work results in greater accomplishments than each group working on its own could ever achieve (Lasker et al. 2001).

Coalitions achieve their goals by pooling resources, combined with assessing a situation and selecting actions that target the most critical determinants of a particular problem. Once a coalition is formed and has its structures and processes in place, one of its first priorities is often to conduct a community assessment. Community assessment is the process of understanding a community

in terms of its strengths, needs, constituencies, history and politics, leadership structure, and related factors that affect community problem solving (Bartholomew et al. 2006; see also chapter 9). Assessment also involves identifying a priority health issue or social issue, determining whom it affects disproportionately, and assessing its behavioral and environmental determinants. According to CCAT, coalitions that conduct comprehensive community assessments are better positioned to select and implement strategies that will make a difference.

Successful implementation depends on numerous factors, such as sufficient resources, completion of tasks on schedule, fidelity to the planned strategies, and supportive organizational and community environments. Assuming the strategies link logically to planned outcomes, the likelihood of achieving these outcomes depends on the extent to which the strategies are implemented and reach the priority populations. Adaptations of interventions that have been previously evaluated (evidence based) or are commonly accepted as best practices increase the likelihood that interventions will result in community change and, ultimately, desired health and social outcomes.

Most researchers and practitioners agree that effective health promotion efforts require change at multiple levels, including environmental and policy change. Using best practices or evidence-based interventions should minimize the tendency of coalitions to focus on building community awareness. A focus on quick wins may help to maintain member interest, but is unlikely to lead to more valued outcomes and may explain why some coalition-based efforts are not able to achieve systems or health outcomes change (Kreuter et al. 2000).

Community context affects the coalition planning and implementation process in a variety of ways (Kegler et al., in press). For example, geography can shape assessment methods, community history and valuing of collaboration can facilitate sharing of resources, and historical divides can affect who participates in coalition activities.

Institutionalization: Planning for Sustainability

Most communities currently face a tough environment with limited and shorter funding cycles, increased competition for resources, and economic downturns. Sustainability often is misunderstood as involving only sustained funding, since when the funding ends, so does the commitment. However, sustainability does not depend on one strategy, policy, or approach, but instead requires developing community understanding and leadership to embed new solutions in institutions—literally, *institution*alizing polices and organizational practices within community norms. With this understanding of sustainability, even if funding and efforts diminish, health has been embedded and lasting change remains (CDC 2011).

Despite their critical role in promoting health and preventing disease, many coalitions are unable to sustain their efforts long enough to change policies, systems, and environments. In order to create and build momentum to maintain

community-wide change, coalitions must fulfill their missions and be effectively managed and governed. Sustainable coalitions (1) develop strong, experienced leaders; (2) have broad, deep organizational and community ties; (3) coordinate efforts; (4) implement evidence-based interventions; and (5) allow adequate time for sustainability planning (Feinberg et al. 2008; Nelson et al. 2007). Sustainability planning should begin early and continue throughout the life of the coalition. A sustained coalition will be more likely to attract varied funding sources and establish credibility among its constituency and policymakers (CDC 2008).

Besides developing coalitions and partnerships, sustainability involves initiating a groundswell of community strategies that create change at the local level and assembling a wide range of disciplines to work with communities to improve their health. Sustainability can be considered from short- and long-term perspectives (CDC 2011). *Short-term sustainability* deals with tasks that must be done to keep a strategy in place long enough to achieve its objectives. It means having buy-in and support from key decision makers and community volunteers; having sufficient leadership and funding, as well as clear communications; and putting procedures in place to monitor results and modify strategies that are not working. *Long-term sustainability* is more proactive and future oriented. It means (1) having a long-term plan for assuring the viability of an organization or a community-led initiative that manages several policy, systems, and environmental change strategies; (2) developing a diverse funding portfolio, collaborative leaders, and marketing/branding strategies; and (3) ensuring that the community, its organizations, and strategies are ready to respond to changes in the environment.

Future of Coalition Approaches

With the advent of evidence-based medicine and outcomes-based interventions, coalitions have been criticized as not meeting expectations for success (Green 2000; Hallfors et al. 2003). Given the tremendous infusion of resources, both monetary and in donated volunteer time, some feel that this criticism is well deserved. In truth, the overall evidence for positive coalition outcomes is modest. Traditional scientific methodology may not be adequate to capture the outcomes of these complex collaborative organizations (Berkowitz 2001; Gabriel 2000; Merzel and D'Affliti 2003).

Future research efforts should focus on what coalitions contribute to community-based strategies above and beyond more traditional approaches (Lasker et al. 2001; Berkowitz 2001; Butterfoss et al. 2001). For example, do coalitions develop more innovative strategies due to the pooling of expertise and resources? Do they reach previously untapped community assets? Are they better able to implement certain interventions, such as policy or media advocacy efforts, than are traditional public health and social service agencies? What are the long-term benefits and unintended positive outcomes for communities?

Community coalitions, like other community-level initiatives, are challenged to document intermediate and long-term outcomes and attribute resulting changes to the initiative (Florin et al. 2000; Gabriel 2000). Through strengthening the theoretical base and developing a model of action for community coalitions, this area of scientific inquiry will be advanced. Researchers and evaluators with access to large numbers of coalitions are challenged to use the CCAT model to field-test our assumptions and advance the understanding of which coalition characteristics and interactions are most likely to fuel goal attainment. Practitioners, the frontline coalition pioneers, will determine whether this model is useful to increase local support and capacity for further coalition development.

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REFERENCES

Bartholomew, L., G. Parcel, G. Kok, and N. Gottlieb. 2006. *Planning Health Promotion Programs: An Intervention Mapping Approach*. 2nd ed. Jossey-Bass: San Francisco.

Berkowitz, B. 2001. "Studying the Outcomes of Community-Based Coalitions." *American Journal of Community Psychology* 29, no. 2:213–28.

Braithwaite, R., S. Taylor, and J. Austin. 2000. *Building Health Coalitions in the Black Community*. Thousand Oaks: Sage.

Butterfoss, F., S. Cashman, P. Foster-Fishman, and M. Kegler. 2001. "Roundtable Discussion of Berkowitz's Paper." *American Journal of Community Psychology* 29, no. 2:229–40.

Butterfoss, F., R. Goodman, and A. Wandersman. 1993. "Community Coalitions for Prevention and Health Promotion." *Health Education Research* 8, no. 3:315–30.

Butterfoss, F., M. Kegler, and V. Francisco. 2008. "Mobilizing Organizations for Health Promotion: Theories of Organizational Change." In *Health Behavior and Health Education: Theory, Research, and Practice*, edited by K. Glanz, B. Rimer, and V. Viswanath, 335–61. 4th ed. San Francisco: Jossey-Bass.

Butterfoss, F. D. 2007. *Coalitions and Partnerships for Community Health*. San Francisco: Jossey-Bass.

Butterfoss, F. D., L. A. Gilmore, J. W. Krieger, L. L. LaChance, M. Lara, J. R. Meurer, E. A. Nichols, C. E. Orians, J. W. Peterson, S. W. Rose, et al. 2006. "From Formation to Action: How Allies Against Asthma Coalitions Are Getting the Job Done." Supplement, *Health Promotion Practice* 7, no 2:34–43.

Butterfoss, F. D., and M. C. Kegler. 2002. "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory." In *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 157–93. San Francisco: Jossey-Bass.

———. 2009. "Community Coalition Action Theory." In *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 236–276. 2nd ed. San Francisco: Jossey-Bass.

Butterfoss, F. D., L. L. LaChance, and C. E. Orians. 2006. "Building Allies Coalitions: Why Formation Matters." Supplement, *Health Promotion Practice* 7, no 2:23–33.

Centers for Disease Control and Prevention (CDC). 2008. *Best Practices Users Guide: Coalitions—State and Community Interventions.* St. Louis, Mich.: U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. http://www.cdc.gov/tobacco/stateandcommunity/bp_user_guide/pdfs/user_guide.pdf.

———. 2011. A *Sustainability Planning Guide for Healthy Communities.* Division of Adult and Community Health, Healthy Communities Program. http://www.cdc.gov/healthycommunitiesprogram/pdf/sustainability_guide.pdf.

Chávez, V, M. N. Minkler, N. Wallerstein, and M. Spencer. 2010. "Community Organizing for Health and Social Justice." In *Prevention Is Primary: Strategies for Community Well-Being*, edited by V. Chávez, L. Cohen, and S. Chehimi, 87–112. 2nd ed. San Francisco: Jossey-Bass.

Clarke, N. M., L. J. Doctor, A. R. Friedman, L. L. Lachance, C. R. Houle, X. Geng, and J. A. Grisso. 2006. "Community Coalitions to Control Chronic Disease: Allies Against Asthma as a Model and Case Study." Supplement, *Health Promotion Practice* 7, no. 2:14–22.

Crowley, K. M., P. Yu, and S. J. Kaftarian. 2000. "Prevention Actions and Activities Make a Difference: A Structural Equation Model of Coalition Building." *Evaluation and Program Planning* 23, no. 3:381–88.

Dowling, J., H. J. O'Donnell, and Wellington Consulting Group. 2000. *A Development Manual for Asthma Coalitions.* Northbrook, Ill.: CHEST Foundation and American College of Chest Physicians.

Feighery, E., and T. Rogers. 1990. *Building and Maintaining Effective Coalitions.* Palo Alto, Calif.: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention.

Feinberg, M. E., D. E. Bontempo, and M. T. Greenberg. 2008. "Predictors and Level of Sustainability of Community Prevention Coalitions." *American Journal of Preventive Medicine* 34, no. 6:495–501.

Florin, P., R. Mitchell, J. Stevenson, and I. Klein. 2000. "Predicting Intermediate Outcomes for Prevention Coalitions: A Developmental Perspective." *Evaluation and Program Planning* 23:341–46.

Gabriel, R. 2000. "Methodological Challenges in Evaluating Community Partnerships and Coalitions: Still Crazy after All These Years." *Journal of Community Psychology* 28, no. 3:339–52.

Gray, B. 2000. "Assessing Inter-organizational Collaboration: Multiple Conceptions and Multiple Methods." In *Cooperative Strategy: Economic, Business, and Organizational Issues*, edited by D. Faulkner and M. de Rond. 243–260. New York: Oxford University Press.

Green, L. 2000. "Caveats on Coalitions: In Praise of Partnerships." *Health Promotion Practice* 1, no. 1:64–5.

Hallfors, D., H. Cho, D. Livert, and C. Kadushin. 2002. "'Fighting Back' against Substance Abuse: Are Community Coalitions Winning?" *American Journal of Preventive Medicine* 23, no. 4:237–45.

Himmelman, A. 2001. "On Coalitions and the Transformation of Power Relations: Collaborative Betterment and Collaborative Empowerment." *American Journal of Community Psychology* 29, no. 2:277–84.

Jackson, D., and W. Maddy. 2001. "Introduction to Coalitions." Ohio State University Fact Sheet CDFS-1. Columbus, Ohio: Ohio Center for Action on Coalitions. http://ohioline.osu.edu/bc-fact/0001.html.

Kadushin, C., M. Lindholm, D. Ryan, A. Brodsky, and L. Saxe. 2005. "Why It Is So Difficult to Form Effective Community Coalitions." *City and Community* 4, no. 3:255–75.

Kawachi, I., S. V. Subramanian, and D. Kim. 2008. *Social Capital and Health.* New York: Springer Science and Business Media.

Kegler, M., B. Norton, and B. Aronson. 2007. "Skill Improvement among Coalition Members in the California Healthy Cities and Communities Program." *Health Education Research* 22, no. 3:450–57.

Kegler, M., J. Rigler, and S. Honeycutt. 2010. "How Does Community Context Influence Coalitions in the Formation Stage? A Multiple Case Study Based on the Community Coalition Action Theory." *BMC Public Health* 10:90.

———. In press. "The Role of Community Context in Planning and Implementing Community-Based Health Promotion Projects." *Evaluation and Program Planning.*

Kegler, M., C. Williams, C. Cassell, J. Santelli, S. Kegler, S. Montgomery, et al. 2005. "Mobilizing Communities for Teen Pregnancy Prevention: Associations between Coalition Characteristics and Perceived Accomplishments." Supplement, *Journal of Adolescent Health* 37, no. 3:31–41.

Kreuter, M., and N. Lezin. 2002. "Social Capital Theory: Implications for Community-Based Health Promotion." In *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 228–54. San Francisco: Jossey-Bass.

Kreuter, M., N. Lezin, and L. Young. 2000. "Evaluating Community-Based Collaborative Mechanisms: Implications for Practitioners." *Health Promotion Practice* 1 no. 1:49–63.

Lasker, R., E. Weiss, and R. Miller. 2001. "Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage." *Millbank Quarterly* 79, no. 2:179–205.

Mattesich, P., M. Murray-Close, and B. Monsey. 2001. *Collaboration: What Makes It Work; A Review of the Research Literature on Factors Influencing Successful Collaboration*. 2nd ed. St. Paul, Minn.: Amherst H. Wilder Foundation.

Merzel, C., and J. D'Affliti. 2003. "Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential." *American Journal of Public Health* 93, no. 4:557–74.

National Cancer Institute. 2005. "ASSIST: Shaping the Future of Tobacco Prevention and Control." Tobacco Control Monograph no. 16. Bethesda, Md.: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute.

Nelson, D. E., J. H. Reynolds, D. A. Luke, N. B. Mueller, M. H. Eischen, J. Jordan, R. B. Lancaster, S. E. Marcus, and D. Vallone. 2007. "Successfully Maintaining Program Funding during Trying Times: Lessons Learned from Tobacco Control Programs in Five States." *Journal of Public Health Management and Practice* 13, no. 6:612–20.

Putnam, R. 2000. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon and Schuster.

Roussos, S., and S. Fawcett. 2000. "A Review of Collaborative Partnerships as a Strategy for Improving Community Health." *Annual Review of Public Health* 21:369–402.

Wendel, M., J. Burdine, K. McLeroy, A. Alaniz, B. Norton, and M. Felix. 2009. "Community Capacity: Theory and Application." In *Emerging Theories in Health Promotion Practice and Research*, edited by R. DiClemente, L. Crosby, and M. C. Kegler, 277–302. 2nd ed. San Francisco: Jossey-Bass.

Wolff, T. 2010. *The Power of Collaborative Solutions: Six Principles and Effective Tools for Building Healthy Communities.* San Francisco: Jossey-Bass.