

## *Four*

### BUILDING HEALTHY COMMUNITIES

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#### HEALTHY COMMUNITIES: A PARABLE OF TWO PATHS

**I**N the early 1920's, the people of Prairie Center and Sunflower enjoyed a rich community life. There were strong ties among neighbors. People supported each other in many informal ways; through churches, in conversations at the local cafe, and on front porches. Adults cared for children not their own. When Billy or Maria did something wrong, their parents were sure to hear about it. People trusted others to look out for them.

Gradually life changed in each community. Growth from nearby urban areas added people with limited ties to the community. Local zoning laws—and regional planning—separated the places where people worked from those where they lived. Roads now cut through established neighborhoods, making it necessary to take the car to places people used to walk.

Individuals and families made new choices about how to use their time. Rather than visit neighbors, people stayed at home and watched television. Increasingly, both adults worked outside the home; often at several low-paying jobs to meet family needs. As a result, there were fewer

adults to mind what kids were doing. All these individual choices and constraints added up: community folks had less contact with their neighbors, with their children, and with others' children.

In Prairie Center, things changed gradually, and so did the way local people addressed their problems. As drug use and violence increased in the 1980's and 1990's, the local media put the blame on youth and their parents. Following advice from outside experts, the county jail was expanded at considerable cost. This left less public money for education and health. Those who could afford it sent their children to private schools. Those who could went out of town for health care. Poor people suffered the most; sharp cuts in public assistance could not be made up by local churches and charities.

People still cared deeply about their OWN children and family members. But the sense was that each person and family should take care of themselves. Many people were increasingly distrustful of THEM. "Them" was all those outside the family.

The people of Sunflower took a different approach. A tragedy in the late-1980's, deaths of

two children in a drug-related incident, got people's attention. They began a process of community renewal. They started a dialogue about what really mattered to local people, and what values they shared. They identified a common purpose: creating a caring place for all children.

The people of Sunflower began to work together in new ways. They formed action teams that cut across the usual boundaries, including both the powerful and those "labeled" people, such as youth and low-income families, who were seen by some as the problem. Now a diverse group of citizens, public officials, clergy, service providers, and business people joined hands. They worked to transform schools, businesses, health and human service organizations, the faith community, and other valued assets. They established benchmarks for success—all kids succeeding in school, less drug and alcohol use, fewer teen pregnancies, fewer children living in poverty, and adults employed in decent jobs. They coordinated efforts in what they called the "Sunflower Partnership."

Gradually, people started to notice a difference with the unfolding of community changes, both large and small, in Sunflower. Several major businesses allowed flextime for their employees so they could help children. The school district expanded the hours of neighborhood schools, creating safe places for children after school. The faith community collected "pledges" to care for others. City government officials approved new guidelines for tax abatements that rewarded businesses for creating better paying jobs for the unemployed and working poor.

Taken together, these hundreds of changes improved community life. The differences could be seen: slowly, gradually. They also produced results: kids did better in school, fewer kids got in trouble, the neighborhoods were safer, and children and adults were more successful. There was more to be done, of course, but people saw signs of progress.

People from diverse backgrounds connected

with each other in neighborhoods, workplaces, and around issues that mattered to them. They minded each other's children. They looked out for one another. They worked together in common purpose. In short, local people were more fully involved in the ongoing work of building a healthy community.

#### BUILDING HEALTHY COMMUNITIES: SOME ORIENTING IDEAS

**B**UILDING healthy communities is the process of people working together to address health and development concerns that matter to them. As a process of community development<sup>1</sup>, it is ongoing and gradual; not a one-time response to a political issue, such as crime, or an isolated campaign to address a crisis such as a drug-related tragedy. As a continuum of outcomes, it unfolds over time as incremental community (and systems) change, and related improvement in more distant indicators. Social ties and trust may contribute to, and result from, people working together in common purpose. Several orienting ideas help us understand this process of "building healthy communities."

*Community* refers to people who share a common place, experience, or interest. People may come together around issues that affect their place: the local block, neighborhood, city, town, or workplace. They may also connect because of shared experience, such as discrimination, due to race, ethnicity, disability, income, or gender. Finally, people may find common purpose based on shared interests, such as concern with addressing child hunger, neighborhood safety, or drug use. In dialogue, we discover the commonality and diversity of experiences and interests that can unite people in place-based work.

*Health* (of individuals) can be defined as a state of complete physical, mental, and social well-being.<sup>2</sup> It refers to "a state of well-being and the capability to function in the face of challenging

circumstances".<sup>3</sup> Health is not merely the absence of disease or infirmity.<sup>4</sup> Health is seen as a resource for everyday life, not the objective of living.<sup>5</sup>

*Community health*, also known as population health, refers to the state of collective well-being of people who share a common place or experience. What's the level of well-being for all of us who share this place? For our children and adolescents? For adults and older adults in our community? For the poor?

Community health and development issues that matter to local communities include those affecting: a) Physical well-being; for example, decent jobs, adequate housing, violence and public safety, child hunger and nutrition, teen pregnancy, cardiovascular diseases, and injury; b) Mental well-being; for instance, substance abuse, academic failure, depression, and having meaningful work; and c) Social well-being; for example, caring relationships between children and adults, independent living of older adults, and support among family members, peers, and neighbors. Efforts to improve population health focus on changing the conditions in which health occurs.<sup>6</sup>

*Determinants of health* refer to conditions that affect health and well-being.<sup>7</sup> These include the: a) social environment and prosperity (e.g., family structure; educational system; health services; social networks; social class; household income; disparity of income); b) physical environment (e.g., barriers in the physical design of the environment; exposure to hazards and toxic substances; poor housing conditions and overcrowding); and c) genetic endowment (i.e., hereditary factors that increase or decrease risk for health outcomes; e.g., the biological basis for alcoholism, mental disorders, and heart disease).<sup>8</sup> *Social determinants* refer to those environmental features, such as trust and social ties, that affect health and well-being through relationships and exchanges among people.

#### SOCIAL DETERMINANTS, SOCIAL CAPITAL, AND COMMUNITY CAPACITY

**P**OPULATION-LEVEL research—with whole communities, states, and nations—suggests the strong effects of economic circumstances and social features on a community's health status. For example, Wilkinson's<sup>9</sup> cross-national, comparative research showed a strong correlation between income inequality, the gap between those with most and least income, and death from a variety of causes. Kaplan and colleagues,<sup>10</sup> using data from all 50 states of the United States, demonstrated a similar relationship between income distribution and mortality. Also, research with British civil servants by Marmot and colleagues<sup>11</sup> suggests a strong inverse relationship between social class (i.e., job classification) and mortality. In a rare experimental study, a marked increase in income (due to a negative income tax) resulted in improved health outcomes (i.e., fewer low-birthweight babies).<sup>12</sup> In a comprehensive review of the literature on social determinants of health, Feinstein<sup>13</sup> concluded that there is a strong and consistent link between wealth, education, and health outcomes. Yet income disparity has grown in the United States since 1973, with the rich getting richer and the poor getting poorer.<sup>14 15</sup>

The idea of *social capital*—civic engagement and trusting relationships among people—is thought to help explain how income is associated with outcomes in health and development.<sup>16 17</sup> Kawachi and colleagues<sup>18</sup> examined the relationships among income inequality, social capital (civic engagement and level of trusting relationships) and health outcome (all-cause mortality) at the state level. Their research suggests that the more social capital (civic engagement and trust), the better the health outcome. Further, researchers speculate that a decline in social capital—people watching more television, and accordingly, less engaged with their neighbors—

may help explain a rise in a variety of adverse societal outcomes.<sup>19 20</sup>

Less clear are the mechanisms by which social determinants (including poverty and social capital) might influence health and development outcomes. For example, does social capital increase the likelihood that people will be able to transform the environment in ways that improve health? Perhaps when people trust each other, they are more likely to be engaged in community building efforts. Or, is social capital a by-product of successful efforts to transform communities, and related health improvement? Perhaps as communities improve, more people get involved and trusting relationships are developed. Or, does increased social capital affect health directly? For instance, a sense of belonging may reduce stress and improve physical and mental health. Do other factors—perhaps poverty and income disparity, and related stressors and barriers—affect the conditions under which both health and social ties occur? Perhaps the stressors of trying to meet basic needs in the face of poverty reduce access to health resources and the basic conditions that affect health. Also, social comparisons that focus on disparities in wealth between community members may limit their willingness to connect with others, or to get involved on their behalf. Further research may help clarify how income inequality and social capital—and related variables—interact to affect community health and development.

Although social scientists<sup>21 22</sup> have asserted the importance of social capital and cited possible reasons for its apparent decline, few have brought forth tangible ways of how communities can propagate it.<sup>23 24</sup> One promising strategy for enhancing social capital—and less directly, income inequality and community health—is to support collaborative partnerships. Collaborative partnerships are ecological systems<sup>25</sup> that encourage community engagement around local concerns.<sup>26</sup> They create niches of opportunity for, and reduce barriers to, successful community engagement; and, thereby, may increase trust.

They can encourage community engagement that transforms the local environment, and the broader policy and systems changes that produce a more equitable distribution of resources.<sup>27</sup> By increasing civic engagement and equality of opportunity and result, collaborative partnerships focus on two variables associated with health and development outcomes: social capital and income inequality.

Finally, success in addressing the determinants of health may be related to community capacity. *Community capacity* refers to the ability of local people to work together to affect conditions and outcomes that matter to them; and to do so over time, and across concerns.<sup>28 29</sup> Markers of community capacity include community action and resulting change in conditions and outcomes (e.g., community and systems change; improvement in community-level indicators). To reflect capacity, community (systems) changes should occur *over time* (i.e., be sustained) and *across concerns* (i.e., when a new issue or goal is identified, changes are brought about related to these new goal areas).

#### UNDERSTANDING THE CONTEXT OF PUBLIC PROBLEM SOLVING

**B**UILDING healthy communities requires public problem solving: people engaged in addressing issues of health and development that matter to them. Community-wide engagement in public problem solving is affected by our assumptions about the nature of public life, problems, and solutions.<sup>30</sup> Some assumptions, such as that solving problems together builds trust, may advance common work; others, such as “nothing works,” may impede it.

First, assumptions about the nature of public life—and who is responsible for public problems—can enhance or impede the work.<sup>31</sup> Two myths may be central to disengagement of citizens from public life: first, the notion that public life is a battleground for selfish interests; and second, that public life is only for experts,

officials, and celebrities.<sup>32</sup> Business and special interests do have disproportionate influence; and public life does bring together people with different values, and disagreement, even conflict, may result. But self-interest and conflict are not the core of public life. Indeed, public life is also a vehicle for individual and community growth. We all have a public life. Through ties in our family and workplace, and with friends and neighbors, we help each other deal with what matters: serving and being served, protecting and being protected.

Second, beliefs about the nature of public problems—for example, whether problems originate in people<sup>33</sup> or in their environments<sup>34</sup>—may limit or advance community engagement in problem solving. Too often, we frame public problems as being in *those* people abusing substances or in *that* group with the high crime rate.<sup>35</sup> This prevents others from seeing how the problem affects their lives, and from participating in the solution. More truthfully, public problems are shared by all of us. For example, the health and development outcomes for a child born addicted to drugs are not only related to conditions in the past and current environment; they are also tied to future economic security and well-being for that child, his or her family, and the community. Crime and violence associated with poverty not only affect the businesses, playgrounds, and streets of low-income neighborhoods; they extend into, and originate from, the surrounding community.

Similarly, societal issues—such as child health, academic success, or substance abuse—do not fit into neat categories. The factors, such as social support or access to resources, that put people at risk for (or protect them against) one outcome affect other outcomes as well.<sup>36</sup> Defining problems more inclusively, as interconnected with other issues, allows us to see their, and our, interdependence.

Finally, how we define a problem also affects how we attempt to solve it. Limiting myths about solutions are tied to false assumptions of

independence: that my problems are separate from yours; and, therefore, my solutions should be too. This valuing of individual effort is evident in beliefs like “Government causes problems, it doesn’t solve them,” or that “Only I can solve my problems.” Although these assertions might be rooted in some partial truths—for example, that personal responsibility is important—they can also discourage people from working together to solve public problems. To build healthy communities, we must discover the assets of individuals and organizations—including those thought to be part of the problem—that can be brought together in common purpose.<sup>37</sup>

#### ADVANCING THE WORK TOGETHER: SOME PRINCIPLES, ASSUMPTIONS, AND VALUES

**D**ETERMINATION of community health—what causes collective well-being—is complex and multidimensional.<sup>38</sup> Health and development outcomes are affected by an array of interrelated personal and group factors (including competence and biological capacity) and environmental factors (including support and resources, barriers and hazards, preventive and treatment services, poverty, policies, and culture). For example, a mother and father with several low-paying jobs have limited time for their children and may smoke cigarettes to cope with the financial stress. Their young children may spend less time in adequate childcare and have higher exposure to second-hand smoke and other environmental hazards (e.g., cockroaches and lead paint) from poor housing. Limited engagement with adults may diminish early childhood development; exposure to environmental hazards may increase their risks for chronic disease; and these may interact to reduce prospects for academic achievement and adequate employment, for the children and for their children.

The work of building healthy communities requires the ongoing contribution of—and trust

among—individuals and organizations from all sectors or parts of the community. The related determinants of community health demand solutions from multiple sectors (e.g., business, health organizations, media, and government).<sup>39 40</sup> Singular and fragmented approaches that target one issue (e.g., a campaign to reduce tobacco use) or sector (e.g., health organizations or schools) are unlikely to effect community-level outcomes. Rather, promoting community health is a developmental process: an unfolding of integrated, comprehensive, community and systems changes toward common goals.

*Some Guiding Principles, Assumptions, and Values*  
When made explicit, assumptions and values help others to critically evaluate the work and to

understand what success would look like for practitioners.<sup>41</sup> Table 1 outlines 10 principles, assumptions, and values for guiding the work of building healthy communities. For example, Principle #3 highlights the value of community self-determination: a healthy community is a local product with priority issues and strategies best determined by those most affected by the concern. Similarly, Principle #9 underscores the importance of building capacity to address what matters to local people over time and across concerns. Taken together, these 10 principles, assumptions, and values may help guide the interconnected work of a diverse group of people and organizations in transforming the conditions that affect community health. Such development efforts involve interdependent relationships

Table 1

*Some Principles, Assumptions, and Values that Guide the Work of Building Healthy Communities*

1. Community health improvement involves the *population* as a whole, not merely individuals at risk for specific physical, mental, or social conditions.
2. Community health requires changes in both the *behaviors* of large numbers of individuals *and* the *conditions* or social determinants that affect health and development.
3. A healthy community is a *local product* with priority issues and strategies best determined by those most affected by the concern.
4. Freedom and justice require reducing income disparities to promote optimal *health and development for all*.
5. Since health and development outcomes are caused by *multiple factors*, single interventions are likely to be insufficient.
6. The conditions that affect a particular health or development concern are often *interconnected* with those affecting other *concerns*.
7. Since the behaviors that affect health and development occur among a variety of people in an *array of contexts*, community improvement requires engagement of diverse groups through *multiple sectors* of the community.
8. Statewide and community partnerships, support organizations, and grantmakers are *catalysts for change*: they attempt to convene important parties, broker relationships, and leverage needed resources.
9. The aim of support organizations is to *build capacity* to address what matters to people over time and across concerns.
10. Community health and development involves *interdependent relationships* among multiple parties in which none can function fully without the cooperation of others.

among multiple parties that share risks, resources, and responsibilities for the work.<sup>42</sup>

### *Toward Broad Collaborative Partnerships*

Efforts to build healthy communities require broad collaborative partnerships in common purpose. This demands horizontal integration—organizations linked across sectors (e.g., school, business, government)—and vertical integration, connections across multiple levels (e.g., neighborhood, community, county, state, region). Multilevel collaboration should include several key partners, including state and community partnerships, support organizations, and grantmakers and governmental agencies.

#### STATE AND COMMUNITY PARTNERSHIPS

Collaborative partnerships link organizations drawn from all relevant community sectors. For example, a community partnership to promote child health might engage citizens and agency representatives in transforming the media, businesses, schools, civic and community organizations, youth organizations, local government, health organizations, the faith community, and financial institutions. Each sector can contribute to the initiative's efforts by intervening with specific risk (and protective) factors, such as social support or access to services, or broader social determinants of health, such as income inequality and educational opportunity.

#### SUPPORT AND INTERMEDIARY ORGANIZATIONS

Some local, regional, and statewide organizations, such as university research centers, provide technical assistance and evaluation in support of statewide and community partnerships. These intermediary organizations can enhance the capacity of community partners by building on core competencies for doing the work (e.g., community assessment, strategic planning, advocacy). Intermediary organizations help assess the needs of collaborative partnerships and provide support that is timely, appropriate, and responsive. For

example, state and county health departments and research organizations can assist community partners by developing health data systems that provide county-level data and other information useful for making decisions. Similarly, university research and public service centers can support collaborative planning, community intervention, and community evaluation to enhance both understanding and improvement of community efforts.

#### GRANTMAKERS AND GOVERNMENTAL AGENCIES

Foundations and governmental agencies can help create the conditions for community partnerships to be successful. First, grantmakers often use requests for proposals to convene groups around common purpose. Second, they provide the multi-year resources needed by both statewide and community partners and intermediary organizations to conduct the agreed-upon work. Third, they broker connections among those working in the same community or on common issues. Fourth, funders also help leverage funding and other resources for comprehensive efforts. Finally, grantmakers and governmental agencies can also help make outcome matter in multi-year grants by awarding bonus grants and outcome dividends contingent on evidence of attaining objectives and outcomes.

#### BUILDING CAPACITY FOR COMMUNITY AND SYSTEMS CHANGE: A THEORY OF CHANGE

A THEORY of change describes how the initiative should work.<sup>43</sup> Figure 1 outlines the framework used by our University of Kansas Work Group to help understand, support, and document the process by which collaborative partnerships do their work. How-to information to support implementation of the theory of change is available on the Internet-based Community Tool Box, <http://ctb.lsi.ukans.edu/>. Based on related models,<sup>44 45</sup> this framework for building capacity for community and systems change

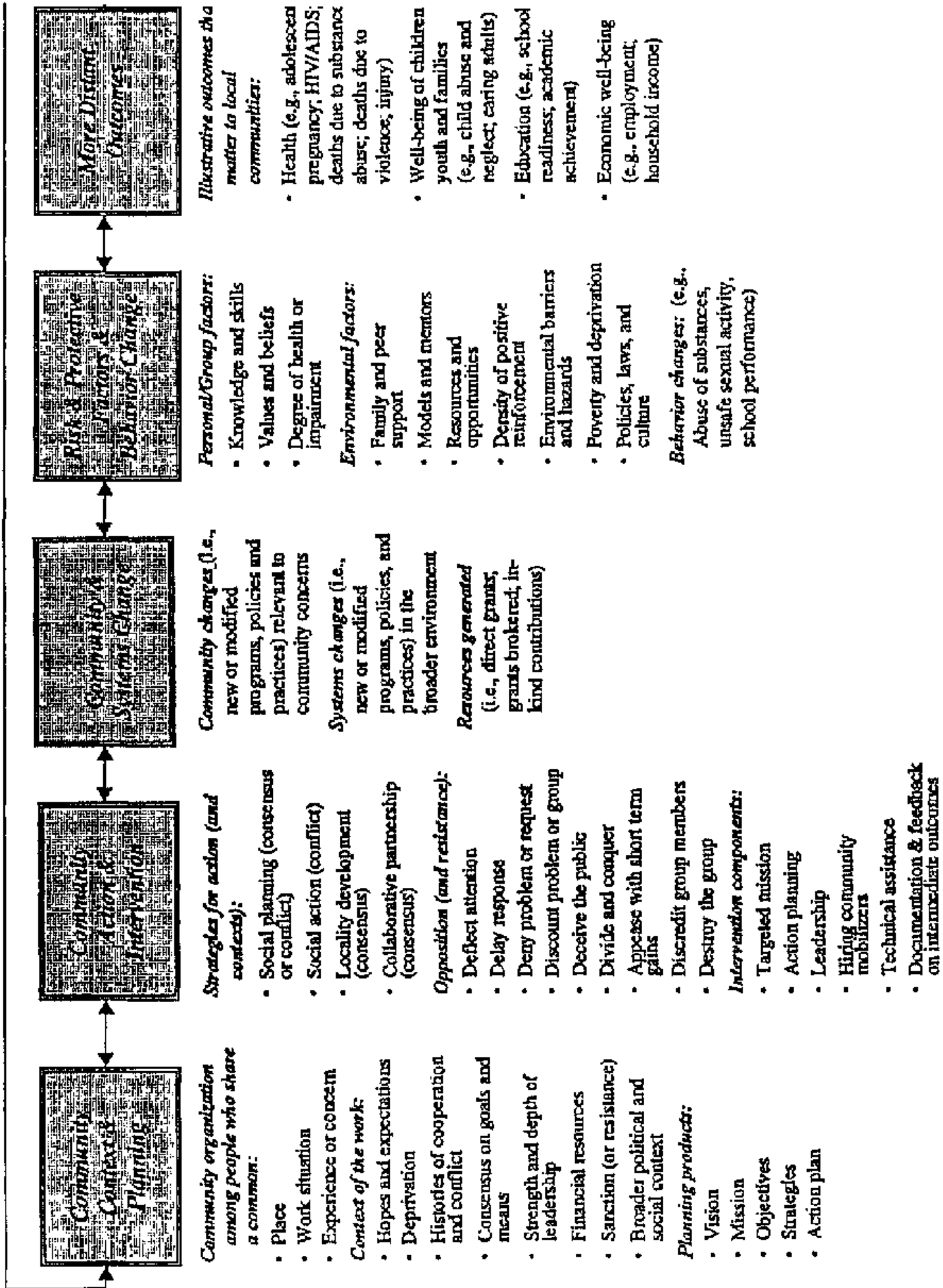


Figure 1  
Building Capacity for Community and Systems Change



includes five components: 1) community context and planning, 2) community action and intervention, 3) community and systems change, 4) risk and protective factors and behavior change, and 5) improving more distant outcomes.

The model is *interactive*. For example, an understanding of the community context, and the ongoing process of collaborative planning, should guide community action and intervention. Similarly, feedback on the effects of the locally determined intervention on community and systems change should influence the context and ongoing planning. The model is also iterative or repeating. For example, achieved levels of improvement in more distant outcomes, such as reduced rates of violence or improved academic success, should lead to a renewed cycle of collaborative planning and intervention for these or other issues that matter to local communities.

### *Community Context and Planning*

The *context*—people's past and current experiences, their dreams for a better life, and the conditions under which people act—frames the practice of promoting community health and development. People's hopes and expectations, such as about whether things can change, influence their willingness to engage in community problem solving. Job and family demands, past histories of responsiveness from those in power, and intensive problems or deprivation may limit people's participation in collaborative planning and other future-oriented community efforts. Individual and group histories of cooperation and conflict, such as gains or losses from prior collaborative or competitive efforts, also affect willingness to work together. Consensus (or lack of agreement) on current goals and means also influences community participation in collective problem solving.

Strong and deep leadership—having a diverse and dispersed team with vision, competence, and persistence—can help inspire and sustain community efforts to address health and develop-

ment issues. Financial resources, such as for hiring community organizers to follow through on action plans, also affect the rate of change. Sanction (or resistance) from the community, or those in authority, influences the likelihood and effectiveness of change. Finally, the broader political and social context, such as political instability or mass protest, may affect the nature of community action and the chances that those in power will respond favorably to the group's efforts to bring about systems change.

*Collaborative planning* is a critical and ongoing aspect of the process of community organization and change for health improvement. People come together to identify issues that matter to them such as drug use, job opportunities, the quality of schools, decent housing, or crime. Community-level indicators, such as archival records of the levels of school failure or violence, help substantiate community concerns and provide benchmarks for detecting improvements on these more distal outcomes.

Inventories of community assets, such as people and materials, help detect resources that can be mobilized in change efforts.<sup>46</sup> Strategic planning can be used to help clarify the community's vision, mission, objectives, and strategies of change. In action planning, local people identify "community changes"—new or modified programs, policies, and practices—to be sought in each relevant sector of the community (e.g., schools, business, government). Similarly, organized community groups may seek "systems changes," new or modified policies and practices at a broader level, such as revised regional planning guidelines to minimize the concentration of poverty in low-income neighborhoods. Community and support teams, such as found in community-based organizations or university-based research organizations, may assist community members in the process of promoting community health and development. In their ongoing planning, community organization efforts bring together people and organizations with diverse experiences and resources—

including poor people, ethnic minorities, youth, elders, and those already with power—to cooperatively plan and implement changes in the community.

### *Community Action and Intervention*

Local planning and analysis of the context help guide *how* community people take action on what matters to them: the strategies for change.<sup>47 48</sup> For example, where the goal is building community capacity and there is consensus on the issues, locality or community development may be a particularly appropriate strategy for bringing people together to pursue a common purpose. Each strategy for promoting community health invokes its own set of intervention components and elements.

Community action often begets a variety of forms of opposition or resistance.<sup>49</sup> Even a relatively benign self-help effort to fix up low-income housing may run into resistance from local officials, evidenced by their deflecting responsibility to others or delaying needed construction permits. Similarly, efforts by a community partnership to redistribute resources from law enforcement to substance abuse prevention will likely be opposed by agencies with interests at stake (and their allies), such as by discounting the value of prevention approaches, denying requests for information, or challenging the legitimacy of the partnership.

Opposition should also be expected when people agree on ends but not means. Consider the case of a public health initiative to reduce teen pregnancy that promotes abstinence and safe sex for those who choose to be sexually active. Opponents may attempt to divide the group on religious grounds (e.g., those for, or against, contraception), or deceive others about the group's purposes (e.g., they are encouraging teens to have sex). When the aim is to redistribute significant power or resources—perhaps by using lawsuits, sit-ins, boycotts, or other disruptive tactics—strong opposition is inevitable. In-

tensive opposition may include attempts to divide members and conquer the weaker organization, appease the group with buyouts that provide short-term gain, discredit leaders with personal attacks, or destroy the organization through a smear campaign in the local media. Community organizations may respond to the opposition, in turn, with appropriate counteractions, such as by reframing the issues, or by going public with opponents' tactics.<sup>50</sup>

### *Community and Systems Change*

Community and systems changes are important intermediate outcomes of community health and development efforts.<sup>51</sup> Community change consists of new or modified programs (e.g., an intergenerational mentoring program), policies (e.g., a business policy to hire local residents for construction jobs in the neighborhood), or practices (e.g., opening public parks to late-night supervised recreation for youth) related to the mission.<sup>52</sup> Similarly, broader systems changes might include a new program of a nearby community college to support computer information networks in community-based organizations, or a change in grantmaking policy to award outcome dividends for improvement in community-level indicators, such as levels of academic performance or affordable housing. Community and systems change may both accompany, and be facilitated by, social ties and trust among affected parties.

Generating resources for community health and development efforts is another desired intermediate outcome. These may include direct grants given and received, funding brokered through relationships with other grantmakers, and in-kind contributions such as professional services and materials. Community leadership, grantmakers and governmental institutions, and intermediary and support organizations collaborate on documenting and communicating information about accomplishments and outcomes. They also assist in generating (or brokering)

resources that can be used to reduce income inequalities and promote community improvement.

#### *Risk and Protective Factors and Behavior Change*

A primary purpose of community and systems change is to alter the context in which people relate to each other. Some features of the person or environment, such as social isolation, may increase the likelihood of adverse outcomes; these are known as risk factors. By contrast, protective factors, such as strong social ties, may decrease the chances of risk behaviors and related adverse outcomes.<sup>53</sup> For example, youth violence may be related to a variety of personal and group factors such as knowledge about the consequences of violence, skill in conflict resolution, and existing health and cognitive abilities of youth and their peers, parents, and guardians. Environmental factors that may affect youth violence include supervision and support from family and friends, models for caring relationships, basic resources, and opportunities for supervised alternative activities after school. Similarly, the amount of social approval and disapproval available for caring (or punitive) relationships with others, poverty and deprivation, and opportunity also add to risk (or protection). Changes in the community (and broader system), and related positive changes in risk and protective factors for the concern, may effect changes in behavior of large numbers of people and associated improvement in more delayed outcomes.

#### *More Distant Outcomes*

Improvements in more distant outcomes, such as reducing violence or increasing employment rates and family incomes, are the ultimate goals of efforts to build capacity for community health and development. Data on community-level indicators sensitive to local concerns (e.g., the percentage of new housing units affordable by those currently without adequate housing) help assess the extent of progress on community-identified

issues associated with development efforts. An annual community report card might communicate information about the state of well-being in the community, trends on community-referenced indicators, and important community changes and success stories related to shared community goals.

#### *Linking Intermediate and More Distant Outcomes: A Working Hypothesis*

A central question for this theory of change is under what conditions are community and systems changes—an intermediate outcome—associated with more distant outcomes. When are changes in programs, policies and practices sufficient to effect community-level outcomes related to group goals (e.g., reduced rates of violence or academic failure)?

Our working hypothesis is that, to effect more distant outcomes, community and systems change must be of sufficient: a) amount (i.e., by goal; e.g., reduce teen pregnancy, increase childhood immunizations), b) intensity of behavior change strategy (i.e., providing information and enhancing skills, facilitating support, modifying access and barriers, changing incentives and disincentives, modifying policies), c) duration (i.e., one-time event, more than once, ongoing), and d) penetration (i.e., to targets of change, such as children or elected officials, through sectors or channels of influence, such as schools or faith organizations, and place-based efforts, such as in specific cities or neighborhoods).

To examine this question, we review multiple case studies for which we have longitudinal data on both community and systems change (an intermediate outcome) and community-level indicators (a more distant marker). For example, to test this working hypothesis with a multi-site initiative to prevent adolescent pregnancy, we might examine whether variations in more distant outcomes (i.e., estimated pregnancy rates) are associated with community and systems changes of varying: a) amount, b) intensity of

behavior change strategy (i.e., improving access to contraceptives, not merely providing information), c) duration (i.e., some ongoing policy and curricular changes, not just one-time social activities), and d) penetration to targets of change (i.e., business leaders, as well as youth) through sectors or channels of influence (i.e., faith organizations and businesses, as well as schools), and place-based efforts (i.e., concentrated in specific neighborhoods where youth might be at particular risk).

#### SOME FACTORS AFFECTING COLLABORATIVE PARTNERSHIPS FOR COMMUNITY HEALTH

OVER nearly a decade, our University of Kansas Work Group has used iterations of this theory of change to help understand—and improve—the functioning of collaborative partnerships for community health and development. We have learned from, and with, over 30 state and local partnerships. The varied contexts included cities, urban neighborhoods, tribes, and rural communities. The partnerships addressed an array of issues including prevention of adolescent substance abuse,<sup>54</sup> adolescent pregnancy,<sup>55</sup> cardiovascular diseases,<sup>56</sup> and promotion of youth development, health and human services, rural health, and urban community development.

In a multiple case study design,<sup>57</sup> our Work Group used a common measurement system to document the unfolding of community and systems changes over time.<sup>58 59</sup> We also used qualitative research methods to identify critical events, such as a change in leadership, in the life history of the partnerships. Using graphs of trends over time, we looked for discontinuities in the pattern of community and systems change, and correlated events that might have effected observed increases (or decreases) in the rate of changes in the environment. By examining whether effects were replicated across different case studies, we were able to examine the generality of a finding that a particular factor, such as

action planning, is associated with increases in the rate of change.

This analysis yielded seven factors or events often associated with marked variations in the rate of community and systems change. Although further research may help determine whether the relationships are causal, their consistency across collaborative partnerships, communities, goal areas, and time is quite remarkable. The following seven factors suggest promising practices for enhancing the functioning of collaborative partnerships.

#### *Targeted Mission*

Having a clear focus—a targeted mission—is one of the most significant contributors to the rate of community and systems change. For initiatives with a targeted mission (e.g., preventing substance abuse or promoting child health), we have seen substantially higher rates of community change than for broad, unfocused “healthy communities” initiatives with no clearly articulated purpose.

#### *Action Planning*

Action planning refers to identifying specific objectives for community and systems change in all relevant sectors of the environment. In the process of action planning, community partnerships identify the actions that will bring about the community changes rated as more important and feasible, and identify who will take those actions, by when they will be done, and what resources (and communication) are needed to get the job done.<sup>60</sup> The completion of action planning, in the context of a targeted mission, has consistently resulted in marked increases in the rates of community and systems change.

#### *Change in (loss of) Leadership*

Involving leaders with a clear vision of how the environment can be transformed to improve community health and development can accelerate the number and intensity of community and

system changes. When such leaders leave the initiative, however, the rate of change often diminishes markedly. A change to such a leader—from one with a less clear vision—can have a facilitating effect. Such leaders see community change goals as niches of opportunity for civic engagement, identify a broader array of change agents (including people affected by the problem), and help create mechanisms by which local people's accomplishments are celebrated.

#### *Resources for Community Mobilizers*

One thing that is very clear is that there needs to be a catalyst—let's call them community mobilizers—to facilitate the efforts of the partnership. They provide follow-up on agreed upon actions. Hiring community mobilizers or organizers has consistently led to increases in rates of community and systems change.

#### *Documentation and Feedback on Intermediate Outcomes*

In the business of community health and development, the product is the capacity of community members to effect change leading to improvement in community-determined outcomes. Such efforts track intermediate markers, such as community and systems change, and benchmarks for more distant community-level outcomes. Tracking the unfolding of community and systems changes over time, and the events that affect them, can help community leadership understand, celebrate, and improve the functioning of collaborative partnerships.

#### *Technical Assistance*

Good leaders work to attract persons with complementary skills, and to enhance the capacity of team members to do the work. Core competencies for doing the work of community health and development—for instance, in action planning or advocacy—often transcend the variety of specific (targeted) missions of the initiatives and specialized training of people doing the

work. The goal of technical assistance is to build community capacity: the ability of local people to effect valued community and systems change—and related more distant outcomes—over time, and across concerns or goal areas.

#### *Making Outcome Matter*

Finally, grantmakers and governmental agencies can greatly facilitate the progress of an initiative by making explicit the contingencies on goal attainment and outcomes achieved. For example, following an announcement from a foundation program officer that continued funding for a multi-year grant to a community partnership was contingent on evidence of progress, the rate of community change increased dramatically.<sup>61</sup> Although untested, promising methods of rewarding results include providing bonus grants for those initiatives that implement important changes and intervention components, and awarding outcome dividends by which communities receive funds saved from improvements in community-level indicators (e.g., rates of teen pregnancy or unemployment).

### TEN RECOMMENDATIONS FOR BUILDING HEALTHY COMMUNITIES

**B**UILDING healthy communities is a local process and product. But the work of local communities can be enhanced by a broader support system, including statewide partnerships, intermediary and support organizations, and grantmakers and governmental agencies. While the former must do the local work, the latter can help create conditions under which it is easier and more likely to be successful. Based on the preceding analysis, ten specific recommendations for building capacity for community change and improvement follow:

1. In collaboration with statewide and community partnerships, grantmakers and governmental agencies should develop and implement a social marketing plan to promote civic engagement in building healthy communities.

- If the marketing plan is successful, larger numbers of people will say (and act accordingly): a) "Things need to change," b) "Working together, we can change things," c) "We should change things," and d) "We must embed programs and policies consistent with these values and goals in our public and private institutions."
  - Messages should refute the myths that reduce civic engagement (e.g., those experiencing public problems are to blame; nothing works).
  - Messages should focus on empowering insights that encourage community involvement (e.g., to reduce and prevent problems, we must change the environments in which people make choices).
  - Messages should promote widespread adoption of specific ideas (e.g., "we are in this together") and practices (e.g., become a mentor or friend to a child not your own). The communications plan should tailor its strategies to reach relevant audiences (e.g., parents and guardians, youth, religious leaders, business leaders).
  - A communications plan should be developed and implemented in collaboration with community partnerships to promote awareness of their local goals and accomplishments (e.g., community and systems changes; improvements in the lives of individuals; success stories; community champions).
  - Use traditional (e.g., print media, storytelling) and modern methods of communication (e.g., broadcast media, the Internet) to disseminate success stories about effective community efforts to promote health and development, and lessons learned in doing the work.
2. Convene statewide and local collaborative partnerships to create comprehensive opportunity structures for civic engagement and promotion of community health and development.
    - Grant funds should help establish and maintain broad multi-issue community partnerships. This would help focus on targeted issues (e.g., task forces for teen pregnancy; employment) within a structure (e.g., action committees for each sector such as schools) that permits coordinated efforts on interrelated issues.
    - Partnerships should involve both influential people (those with access to power) and those most affected by the issue (including youth, the poor, and others experiencing the "problem").
    - Coordinated action committees (and related action plans) should provide multiple niches for community engagement in transforming all relevant sectors of the community (e.g., schools, business, health organizations, media, human service organizations, government, civic organizations, faith community).
  3. Provide information to help focus collaborative efforts on issues and options that most affect health and development, and that matter to local communities.
    - Funding partnerships—among grantmakers in the public, private, and foundation sectors—should help coordinate investments in the same place (e.g., neighborhood, county). They should also permit integrated work across bureaucratic boundaries (e.g., integrated grants for health, education, and economic development).
    - Support organizations should provide information about the social determinants of health and development—highlighting the contributions of poverty and education—to help focus community objectives on reducing the number of children and families in poverty and on increasing early child development, school readiness, and academic achievement.
    - Support organizations should provide information about the incidence (new cases) and prevalence (existing cases) of more specific health and development outcomes (e.g., the rate of adolescent pregnancy) to suggest candidate objectives for statewide and community partnerships.
    - Collaborative partnerships should convene community listening sessions—and assess and analyze community needs and assets—to influence selection of locally-determined objectives and strategies.
    - Support organizations should develop and communicate a theory of change (e.g., building capacity for community and systems change) that helps guide the work.
  4. Support action planning and community intervention that focuses attention on changes in the environment that advance the locally-determined mission and objectives
    - Planning should begin early and be ongoing. Annual action planning can renew efforts; regular updates on progress (and adjustments) can enhance communication and coordination.
    - Promote widespread adoption of promising interventions—what works—while permitting adaptation to fit local conditions.
    - Focus on transforming the environment in

which behavior related to health and development occurs: personal and group factors (e.g., experience and competence) and environmental influences (e.g., social support, resources and opportunities, policies).

- Information about factors that increase risk for (or protect against) adverse health and development outcomes can help focus attention on strategic intervention components and changes in the environment.
  - Seek balance in interventions: universal efforts to reach a broad audience and targeted programs of sufficient intensity to affect outcomes with those at higher risk.
5. Provide coordinated investments in collaborative partnerships for community health—including support for community leadership and change agents—which are large enough and long enough to make a difference.
    - Fund community partnerships long enough to make a difference (e.g., 5 to 10 years).
    - Provide resources to hire community mobilizers or organizers to follow up and support the work of action committees.
    - Continue to generate “small wins” that reward collaborative efforts more immediately while also tackling larger systems changes that demand longer-term engagement.
    - Promote sustainability of successful community partnerships by gradual reduction in long-term funding. Promote institutionalization of their more effective interventions by incorporating them into existing budgets.
  6. Use a variety of methods to build capacity for doing the work.
    - Enhance personal contact among those doing (and supporting) the work. Seek to build the trusting relationships necessary for people to learn from each other.
    - Use distance education methods (e.g., teleconferencing, the Internet) to create and connect distributed learning communities of people doing the work. (This should be accompanied by investment in hardware, materials, training, and support to promote access to, and use of, new technologies.)
    - Use the Internet (e.g., the Community Tool Box, <http://ctb.lsi.ukans.edu>) to disseminate “how-to” information for core competencies of building healthy communities (e.g., community assessment, strategic planning, advocacy, community evaluation).
    - Link newer community partnerships with those
  - more experienced; and more established leaders with newer generations of leadership.
  7. Document the process of community and systems change—new or modified programs, policies, and practices—to enhance mutual learning, accountability, and community improvement.
    - Collaborate with leaders of initiatives to develop meaningful ways to present and use data on community and systems change to promote mid-course adjustments and to attract resources.
    - Acknowledge, honor, and celebrate those organizations and community champions that bring about significant community and systems changes.
    - Use data on community and systems change to promote mid-course adjustments.
    - Provide feedback on key variables in the theory of change: a) the amount of community or systems change by goal (e.g., unemployment, youth development), b) intensity of strategy (e.g., providing information, modifying access), c) duration of the change (e.g., one-time event, ongoing), and d) penetration of the change to reach those at risk (including settings and places experienced by high-risk sub-groups).
    - Examine trends and patterns in community and systems change over time to identify factors (e.g., action planning) that may affect the rates of change.
    - Use an annual state-of-the-partnership report to encourage accountability of statewide and community partnerships to the community and to funders.
  8. Make outcome matter.
    - Establish and report on agreed-upon intermediate outcomes—such as high rates of important community and systems changes—for community-determined goals.
    - Establish and report on agreed-upon more distant outcomes—and related community-level indicators or benchmarks (e.g., estimated pregnancy rate)—for community-determined goals.
    - Establish and report on benchmarks for broader social determinants of health and development (i.e., disparity of income; educational attainment).
    - Make annual renewal of community investments contingent on evidence of progress (e.g., high rates of community and systems change; improvements in behavior and other benchmarks).

- Award bonus grants (e.g., cash awards) to encourage progress in implementation and outstanding accomplishments of community and systems change.
  - Award outcome dividends to reward improvements in longer-term community-level outcomes (e.g., permit communities to reinvest the money saved by reductions in rates of adolescent pregnancy to address other community-determined goals).
9. Develop broad collaborative partnerships—including among statewide and community partnerships, intermediary and support organizations, and grantmakers and governmental agencies—to create a comprehensive and integrated support system for promoting community health and development.
- Create broad collaborative partnerships among diverse organizations and institutions that share risks, resources, and responsibilities for community improvement.
  - Modify reward and opportunity structures within private and public institutions to support civic engagement in public problem solving (e.g., hiring, promotion, and flextime policies of organizations that encourage civic engagement).
  - Statewide and community partnerships, intermediary and support organizations, and grantmakers and governmental agencies should act as catalysts for change by convening people around important health and development concerns, brokering access to people who can help address community issues, and leveraging resources that few communities could access themselves.
10. Future research and dissemination should help understand and enhance the mechanisms that affect community health and development.
- Examine whether (and how) reductions in poverty (and income inequality) and improvements in education effect improvements in community-level indicators of health and development.
  - Examine the conditions under which community and systems change (i.e., amount of change by goal, intensity of behavior change strategy, duration, and penetration of target groups) are associated with improvements in more distant community-level indicators (e.g., rates of adolescent pregnancy, child abuse and neglect, employment, high school completion)

- Disseminate information about “what works” and promising practices for building healthy communities, through a variety of appropriate channels of influence (e.g., print and broadcast media, professional associations, the Internet).

## CONCLUSION

A HEALTHY community is a form of living democracy: people working together—across the usual boundaries—to address what matters to them. As citizens, we have a duty to shape the basic conditions that affect our lives, and the lives of those with whom we share a common place or experience.<sup>62 63</sup> Insofar as building healthy communities is a democratic process, it can create cohesion and reduce mistrust among a diverse group of people. In transforming local communities, we are guided by shared values and principles—including equality of opportunity and social justice—that bind us in common purpose.<sup>64</sup> As citizens, we share a responsibility to work together to solve our common problems.

Community health and well-being are affected by the conditions, modifiable features of the environment, in which people lead their lives. Some social determinants, such as inequality of wealth and poor education, exert strong negative influences on community health; and social capital, including trust and social ties, may enhance it. Future research, perhaps using more ecological assessments,<sup>65</sup> should help us better understand these complex and reciprocal influences. Practice should focus on community and systems changes that transform the context in which health and development are determined. Critical reflection—among collaborative partnerships, support organizations, and grantmakers—should examine how well we are transforming the conditions under which health and development occur.

Building healthy communities blends the particular and the universal, the local and broader contexts.<sup>66</sup> Such efforts are grounded in the



local: the family, the neighborhood, and other familiar communities of interest and place. As such, they build on the shared values and social relationships that inspire trust and build social capital.<sup>67</sup> But to be effective, we must also engage diverse groups—people and organizations “not like us”—and transform the broader conditions—the policies and practices—that affect local work. This requires courage, doubt, and faith: to trust those outside our immediate experience, to question what is, and to believe that together we can make a difference.

Building healthy communities requires an ecological view: seeing the web of interconnectedness that binds people, problems, solutions, and contexts. Systems changes create niches of opportunity for civic engagement, make the work easier, and enhance its value for more people in more places. In a healthy community, individuals pursue common purpose—not for the sake of community alone, but because addressing issues larger than us gives meaning to our lives.

The work of building healthy communities takes time: of us, of our children, and of our children's children. A Jewish proverb counsels: “You are not bound to finish the work, but neither are you free to give it up.”<sup>68</sup> In our emerging ties across place and time, we join others in creating environments worthy of all our children, and in providing models for future generations to engage in this good work.

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