EMERGING THEORIES IN HEALTH PROMOTION PRACTICE AND RESEARCH

Strategies for Improving Public Health

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CHAPTER SEVEN

TOWARD A COMPREHENSIVE UNDERSTANDING OF COMMUNITY COALITIONS

Moving from Practice to Theory

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Communities, organizations, businesses, and even nations today form alliances, joint ventures, and public-private partnerships. One type of strategic relationship, a coalition, develops when different sectors of the community, state, or nation join together to create opportunities that will benefit all of the partners. Community coalitions are a specific type of coalition defined as a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal (Feighery & Rogers, 1990).

The development of coalitions escalated rapidly over the past two decades. Thousands of coalitions anchored by government or community-based organizations formed 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 reduce, and eventually to eliminate, the use of tobacco among youth. Advocates for environmental issues such as asthma and lead contamination have rallied to highlight their issue or enable favorable policy and legislation. Civic and faith-based groups developed coalitions to ensure adequate housing for the elderly and health insurance for the poor. Community coalitions

Community coalitions bring people together, expand available resources, and focus on a problem of community concern to achieve better results than any single group or agency could have achieved alone.

bring people together, expand available resources, and focus on a problem of community concern to achieve better results than any single group or agency could have achieved alone.

Unfortunately, not every coalition has been successful, and not every coalition has achieved its results without having its members pay a high price for its success (Dowling, O'Donnell & Wellington Consulting Group, 2000; Wolff, 2001). Although coalitions are usually built from unselfish motives to improve communities, they still may experience difficulties that are common to many types of organizations, as well as some that are unique to collaborative efforts. With the initiation of a coalition, frustrations often 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. Coalitions are not a panacea. Because coalition building involves a long-term investment of time and resources, a coalition should not be established if a simpler, less complex structure will get the job done or if the community does not embrace this approach.

The premise of this chapter is that public health professionals have eagerly embraced the practice of coalition building. They have looked for an effective, inclusive approach to complex health issues and coalitions fit the bill. The time has come to step back from the practice of building coalitions and forge a comprehensive theory of community coalitions. This theory, complete with constructs and propositions, will lead to an increased understanding of how community coalitions work in practice.

Origins and Roots of the Theory

The underlying theoretical basis for the development and maintenance of community coalitions borrows from many arenas, including community development, citizen participation, political science, interorganizational relations, and group process. Community development and related approaches such as community organization, community empowerment, and citizen participation provide much of the philosophy that underlies community coalition approaches. Coined by the United Nations in 1955, *community development* was designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance on the community's initiative (Brager, Sprecht, & Torczyner, 1987). This approach is based on assumptions that communities can develop the capacity to deal with their own problems; people should participate in making, adjusting, or controlling the major changes taking place in their communities; and changes in community living that are self-imposed or self-developed

have a meaning and permanence that imposed changes do not have. Additional assumptions underlying community approaches to problem solving are that holistic approaches can deal successfully with problems where fragmented approaches cannot, democracy requires cooperative participation and action in the affairs of the community, and people must learn the skills that make this possible.

In a similar vein, *community participation* is the process of involving people in the institutions or decisions that affect their lives (Checkoway, 1989). Citizen participation is the mobilization of citizens for the purpose of undertaking activities to improve conditions in the community. Much of the initial coalition research in the 1990s was based on two significant research efforts in the area of citizen participation. The Neighborhood Participation Project examined the process of citizen participation through a systematic study of block organizations in a Nashville, Tennessee, neighborhood (Florin & Wandersman, 1990; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Prestby & Wandersman, 1985; Giamartino & Wandersman, 1983). Researchers posed questions similar to those posed in coalition research: Who participates, who does not, and why? What are the effects of citizen participation in block organizations? What are the characteristics of organizations that are active and successful versus those that are inactive (Florin & Wandersman, 1990)? Research questions asked in the Block Booster Project in New York City also helped shape the coalition research agenda (Perkins, Florin, Rich, Wandersman, & Chavis, 1990). This project assessed the role of block associations in encouraging community development and increasing a sense of community (Florin & Wandersman, 1990).

Community-based coalitions differ from block organizations. Although some coalition members can be characterized as interested citizens (or volunteers), many of the members represent organizations. Thus, research and conceptual work done in the field of interorganizational relations is also relevant to coalition theory. Much of the early research on interorganizational relations focused on the formation of collaborative relationships in an effort to understand why organizations join collaborative alliances (Gray & Wood, 1991; Berlin, Barnett, Mischke, & Ocasio, 2000; Provan & Milward, 1995).

Gray and Wood (1991) discussed several theoretical perspectives that help to inform interorganizational collaboration. For example, resource dependence theory posits that acquiring resources and reducing uncertainty are the primary forces underlying collaboration (Sharfman, Gray, & Yan, 1991; Mizruchi & Galaskiewicz, 1994). Institutional theory suggests that organizations adjust to institutional directives and norms in an attempt to achieve legitimacy (Gray & Wood, 1991; Gulati, 1995). Finally, political science emphasizes the negotiation of potential conflict through coalitions and power distribution within coalitions (Bazzoli et al., 1997).

Each of these perspectives sheds insight into the formation of community coalitions. For example, community coalitions often form in response to an opportunity, such as new funding exemplified by the tobacco settlement funds made available for coalition building around preventing youth tobacco use. Coalitions may form because of a threat such as a national story about rising asthma prevalence or a local event such as an outbreak of bacterial meningitis on a college campus. Local health organizations may voluntarily form or join coalitions to augment their limited resources of staff, time, talent, equipment, supplies, materials, contacts, and influence. Joining with other agencies and individuals can benefit an organization, giving it expanded access to printing and postage services, media coverage, marketing services, meeting space, community residents, influential people, personnel, community and professional networks, and expertise (Whitt, 1993). In addition, coalition formation may be mandatory or required by a funding source, such as the Robert Wood Johnson Allies Against Asthma initiative.

Another major contribution of the field of interorganizational relations to coalition theory is the fact that organizations decide to join collaborative relationships when the benefits outweigh the costs (Gray, 1989; Prestby et al., 1990; Roberts-DeGennaro, 1986; Whetten, 1981). Ultimately, collaboration is possible when a perceived need exists and an organization anticipates deriving a benefit that is contingent on mutual action (Wood & Gray, 1991). Coalitions offer such benefits by serving as effective and efficient vehicles for the exchange of knowledge, ideas, and strategies. Through coalitions, individuals and organizations can become involved in new, broader issues without assuming sole responsibility. Coalitions can also demonstrate and develop community support or concern for issues; maximize the power of individuals and groups through collective action; improve trust and communication among community agencies and sectors; mobilize diverse talents, resources, and strategies; build strength and cohesiveness by connecting individual activists; build a constituency for a given issue; reduce the social acceptability of health-risk behaviors; and change community norms and standards (Whitt, 1993). Additional benefits include the potential to minimize duplication and use resources efficiently; the opportunity to gain access to new information, ideas, materials, and other resources; the opportunity to reduce uncertainty in the environment; and the sharing of costs and associated risks (Alter & Hage, 1993; Gray, 1989; Whetten, 1981; Zapka et al., 1992; Wandersman & Alderman, 1993; Butterfoss, Goodman, & Wandersman, 1993; Penner, 1995).

The costs associated with coalition membership may include loss of autonomy and the ability to control outcomes unilaterally, conflict over goals and methods, loss of resources (time, money, information, and status), risk of losing competitive position, and possible delays in solving problems (Alter & Hage, 1993).

Community coalitions that survive over time must provide ongoing benefits that outweigh the costs of membership.

Finally, the field of interorganizational relations has contributed to our understanding of the stages of collaboration that community coalitions often experience. Gray (1989), for example, proposed three stages: problem setting, direction setting, and implementation. Similarly, Alter and Hage (1993) suggested a model of network development whereby networks evolve through three stages: from exchange networks to action networks to fully developed systemic networks. According to their model, action networks result when organizations can no longer meet a goal alone due to environmental conditions. A network shifts from an exchange to an action network when members contribute private resources for access to collective output, depend on the collective output, and feel a normative obligation to comply with the coordinating mechanism. An action network shifts to a systemic network when it begins to produce together, with specialized roles.

Although clear and definite theoretical underpinnings exist for community coalitions, the practice of coalition building has outpaced the development of coalition theory. The rise of coalitions as a prominent health promotion strategy parallels the growth of communitywide health promotion over the past two decades. This growth is partially due to the widespread dissemination of strategies employed in the National Heart, Lung and Blood Institutes' community demonstration projects (Mittelmark, 1999). These projects, which include the Stanford Three Community and Five City Projects and the Minnesota and Pawtucket Heart Health Programs, used community advisory boards to plan and implement communitywide cardiovascular disease prevention strategies (Shea & Basch, 1990; Carlaw, Mittelmark, Bracht, Luepker, 1984; Mittelmark et al., 1986; Lefebvre, Lasater, Carleton, & Peterson, 1987; Farquhar et al., 1990). Additionally, the Centers for Disease Control and Prevention (CDC) advocated forming community coalitions in the Planned Approach to Community Health, which was widely adopted by state and local health departments in the late 1980s and early 1990s (Kreuter, 1992; Green & Kreuter, 1992).

In contrast to traditional, individual-focused behavior change efforts, community approaches, including those that build coalitions, attempt to alleviate community problems by organizing the community to bring about change. These communitywide approaches recognize that behaviors are inextricably tied to the environment (Milio, 1989; Thompson & Kinne, 1990; Stokols, 1992; Tesh, 1988). In theory, no single approach for community change is as effective as a broad-based coalition effort

The general focus of community organizing for health promotion is on changing systems, rules, social norms, or laws in order ultimately to change the social acceptability of certain behaviors.

that provides the means for multiple strategies and involves key community individuals (McLeroy, Kegler, Steckler, Burdine, & Wisotzky, 1994). The general focus of community organizing for health promotion is on changing systems, rules, social norms, or laws in order ultimately to change the social acceptability of certain behaviors. The venue for community organizing is often the policy arena and can often involve community elected officials, businesses, community groups, media, and local and state legislatures to create positive community change.

Community coalitions have the potential to involve multiple sectors of the community and to conduct multiple interventions that focus on both individuals and their environments. The pooling of resources and the mobilization of talents and diverse approaches inherent in a successful coalition approach make it a logical strategy for disease prevention based on a social ecological model that acknowledges the significance of the environment on health. The fact that individuals and organizations apply their skills and resources in collective efforts to meet their own needs is also the basis of *community empowerment*. Community empowerment enjoyed a resurgence of interest and also fueled the formation of community coalitions in the early 1990s (Israel, Checkoway, Schultz, & Zimmerman, 1994; Labonte, 1994; Minkler, 1994; Perkins, 1995; Rappaport, 1987; Robertson & Minkler, 1994; Wallerstein, 1992; Zimmerman & Rappaport, 1988).

Finally, interest in how well community coalitions develop the capacity of communities to address future critical health issues is growing. Community coalitions are a promising strategy for building capacity and competence among member organizations and, ultimately, in the communities they serve (Chavis, 2001; Kegler, Steckler, McLeroy, & Malek, 1998b). Associated increases in community participation and leadership, skills, resources, social and interorganizational networks, sense of community, and community power may contribute to future successful community problem-solving efforts (Goodman et al., 1998).

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 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 is thought to increase the chances of successful institutionalization into the community (Bracht, 1990). 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 decade required the formation of community coalitions.

Description of Theory, Constructs, and Assumptions

Certain theoretical underpinnings and assumptions form the framework on which most community coalitions are, or should be, built. A wealth of practice-proven propositions have arisen that provide the basis for grounded theories about the development and maintenance of coalitions, as well as how they result in successful actions and health outcomes. The propositions presented in Tables 7.1 and 7.2 are the rationale behind the Community Coalition Action Theory; Figure 7.1 depicts the theory visually.

The theory applies primarily to community coalitions. A community coalition is different from other types of community entities in that a structured arrangement for collaboration by organizations exists in which all members work together toward a common purpose. If a group is composed solely of individuals and not organizations, then it is not a coalition in its truest form. As an action-oriented partnership, a coalition usually focuses on preventing or ameliorating a community problem by (1) analyzing the problem, (2) gathering data and assessing need, (3) developing an action plan with identified solutions, (4) implementing those solutions, (5) reaching community-level outcomes, such as health

FIGURE 7.1. COMMUNITY COALITION ACTION THEORY.

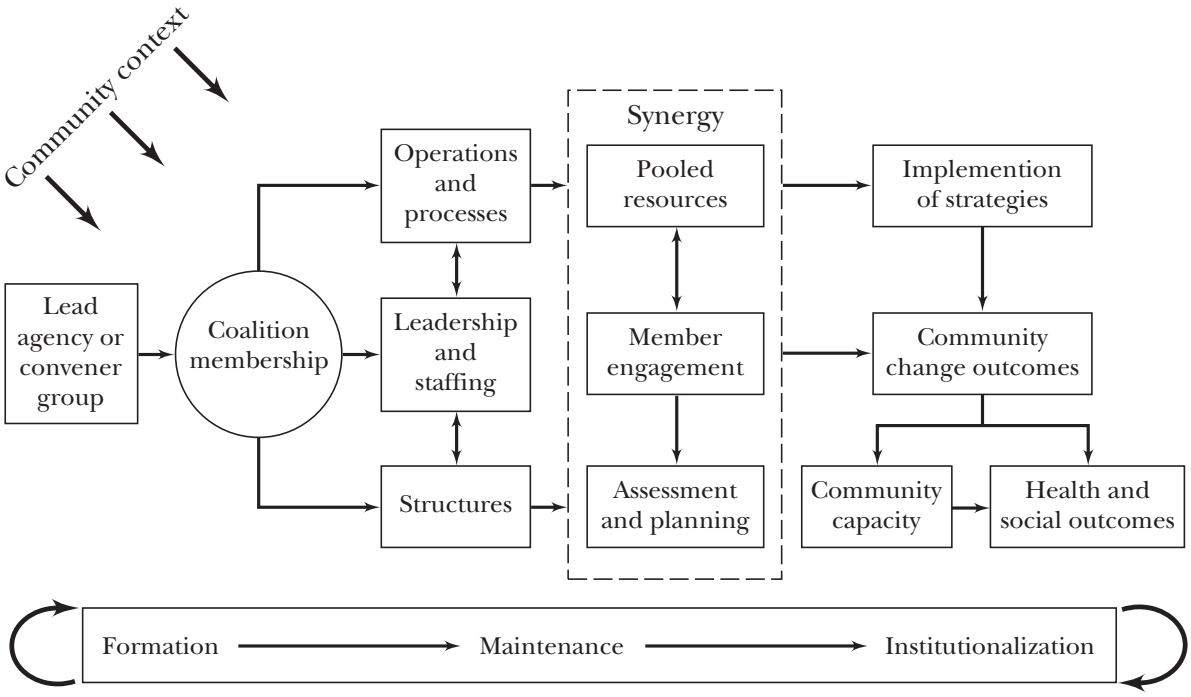

TABLE 7.1. CONSTRUCTS AND PROPOSITIONS RELATED TO COMMUNITY COALITION FORMATION, STRUCTURE, AND PROCESSES.

Constructs	Propositions
Stages of development	*Proposition 1.* Coalitions develop in specific stages and recycle through these stages as new members are recruited, plans are renewed, and new issues are added.
	Proposition 2. At each stage, specific factors enhance coalition function and progression to the next stage.
Community context	*Proposition 3.* Coalitions are heavily influenced by contextual factors in the community throughout all stages of development.
Lead agency/ convener group	*Proposition 4.* Coalitions form when a lead agency or convening group responds to an opportunity, threat, or mandate.
	Proposition 5. Coalition formation is more likely when the lead agency or convening organization provides technical assistance, financial or material support, credibility, and valuable networks and contacts.
	Proposition 6. Coalition formation is likely to be more successful when the convener group enlists community gatekeepers who thoroughly understand the community to help develop credibility and trust with others in the community.
Coalition membership	*Proposition 7.* Coalition formation usually begins by recruiting a core group of people who are committed to resolving the health or social issue.
	Proposition 8. More effective coalitions result when the core group expands to include a broad constituency of participants who represent diverse interest groups, agencies, organizations, and institutions.
Coalition operations and processes	*Proposition 9.* Open and frequent communication among staff and members helps to create a positive organizational climate, ensures that benefits outweigh costs, and makes pooling of resources, member engagement, and effective assessment and planning more likely.
	Proposition 10. Shared and formalized decision-making processes help create a positive organizational climate, ensure that benefits outweigh costs, and make pooling of resources, member engagement, and effective assessment and planning more likely.
	Proposition 11. Conflict management helps to create a positive organizational climate, ensures that benefits outweigh costs, and achieves pooling of resources, member engagement, and effective assessment and planning.
	Proposition 12. The benefits of participation must outweigh the costs to make pooling of resources, member engagement, and effective assessment and planning more likely.
	Proposition 13. Positive relationships among members are likely to create a positive coalition climate.

Constructs	Propositions
Leadership and staffing	*Proposition 14.* Strong leadership from a team of staff and members improves coalition functioning and makes pooling of resources, member engagement, and effective assessment and planning more likely.
	Proposition 15. Paid staff who have the interpersonal and organizational skills to facilitate the collaborative process improve coalition functioning and increase pooling of resources, member engagement, and effective assessment and planning.
Structures	*Proposition 16.* Formalized rules, roles, structures, and procedures make pooling of resources, member engagement, and effective assessment and planning more likely.

TABLE 7.2. CONSTRUCTS AND PROPOSITIONS RELATED TO COMMUNITY COALITION INTERVENTIONS AND OUTCOMES.

Constructs	Propositions
Pooled member and external resources	*Proposition 17.* The synergistic pooling of member and community resources prompts effective assessment, planning, and implementation of strategies.
Member engagement	*Proposition 18.* Satisfied and committed members will participate more fully in the work of the coalition.
Assessment and planning	*Proposition 19.* Successful implementation of strategies is more likely when comprehensive assessment and planning occur.
Implementation of strategies	*Proposition 20.* Coalitions are more likely to create change in community policies, practices, and environment when they direct interventions at multiple levels.
Community change outcomes	*Proposition 21.* Coalitions that are able to change community policies, practices, and environment are more likely to increase capacity and improve health and social outcomes.
Health and social outcomes	*Proposition 22.* The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.
Community capacity	*Proposition 23.* As a result of participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues.

behavior changes, and (6) creating social change (Whitt, 1993). This theory does not apply to short-term grassroots coalitions that form for a specific purpose, such as opposing a landfill, and then disband when the goal is achieved.

Community coalitions are characterized as formal, multipurpose, and long-term alliances (Butterfoss, Goodman, & Wandersman, 1993). The scope of community coalition work tends to be local or regional, and coalitions usually have some paid staff whose time is dedicated to coalition efforts. The size of its membership varies, as does the diversity of professional and grassroots organizations and the individuals who represent these organizations. The degree of formalization of working relationships and role expectations ranges from very formal, with strict adherence to by-laws and contractual relationships, to rather informal.

According to the proposed theory depicted in Figure 7.1, 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 (see Propositions 1 and 2, Table 7.1). The theory also acknowledges contextual factors of the community, such as the sociopolitical climate, geography, history, and norms surrounding collaborative efforts that will have an impact on each stage of coalition development from formation to institutionalization (Proposition 3, Table 7.1).

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.

In the formation stages, a convener or lead agency, with strengths and linkages to the community, brings together core organizations that recruit an initial group of community partners to initiate a coalition effort focusing on a health or social issue of concern (Propositions 4 through 8, Table 7.1). The coalition identifies key leaders and staff, who then develop structures (such as committees and rules) and operating procedures (processes) that promote coalition effectiveness (Propositions 9 through 16, Table 7.1). Structural elements in the coalition ensure that the coalition will adequately assess the community, develop an action plan, and select and implement strategies based on best practices. This stage requires balancing benefits associated with membership to ensure they outweigh any costs of participation.

The maintenance stage involves sustaining member involvement and taking concrete action steps to achieve the goals of the coalition. In public health, these steps usually are assessing, planning, selecting, and implementing strategies (Propositions 19 and 20, Table 7.2). Success in this stage also depends on the mobilization and pooling of member and external resources (Proposition 17, Table 7.2). The coalition relies on resources from members and external sources to design and then implement the planned strategies. Acquisition of resources, combined with a competent planning and implementation process, are precursors to suc-

cessful transition to the institutionalization stage. With adequate resources, members become engaged in assessment, planning, and implementing strategies and experience increased levels of commitment, participation, and satisfaction (Proposition 18, Table 7.2). By implementing strategies of sufficient duration and intensity according to the action plan, shorter-term outcomes such as changes in individual knowledge, beliefs, self-efficacy, and behavior, as well as changes in community systems, policies, practices, and environment, should occur (Proposition 20 and 21, Table 7.2). These intermediate changes should lead to long-term outcomes, such as reductions in morbidity and mortality, or substantive progress toward other social goals (Proposition 22, Table 7.2).

In the institutionalization stage, successful strategies result in outcomes. If resources have been adequately mobilized and strategies effectively address an ongoing need, coalition strategies may become institutionalized in a community as part of a long-term coalition, or they may be adopted by some organizations within the community. 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 23, Table 7.2).

Empirical Support for the Theory

This section describes the practice-proven propositions that accompany the model presented in Figure 7.1 and the empirical evidence that supports the propositions. Each box (or construct) in the model is sustained by one or more propositions. Table 7.1 contains sixteen propositions related to community coalition formation, structure, and processes, and Table 7.2 focuses on Propositions 17 through 23, which are related to community coalition interventions and outcomes. The twenty-three propositions are supported by empirical evidence (Table 7.3) and material from the "wisdom literature" (how-to manuals and guidelines) when empirical evidence is limited.

The studies cited in Table 7.3 are not intended to be a comprehensive review of the coalition literature on each construct in the model. Several recent reviews offer a more comprehensive summary of recent coalition and community partnership research (Roussos & Fawcett, 2000; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Holden, Pendergast, & Austin, 2000; Lasker, Weiss, & Miller, 2000). Rather, the studies listed in Table 7.3 are those that most heavily influenced development of the theory described here. For each of these studies,

TABLE 7.3. EMPIRICAL EVIDENCE SUPPORTING THE COMMUNITY COALITION ACTION THEORY.

	Butterfoss et al. (1996)	Chinman et al. (1996)	Center for Substance Abuse and Prevention (1998)	Fawcett et al. (1997)	Florin et al. (1993)	Kegler et al. (1998a, 1998b)	Kumpfer et al. (1993)	Mayer et al. (1998)	McMillan et al. (1995)	Nelson (1994)	Reininger et al. (1999)	Rogers et al. (1993)
Description of the study												
Number of coalitions[a]	3	3	24	1	35	10	1	2	35	1	3	61
Methods[b]	S,D	S	S,I, D,O	S,I, D,L	S,I, D	S,I, D,O	S,D	F	S,I	D,O	S,I, D,O	S
Stages of development		X			X							
Community context				X		X				X	X	
Lead agency/ convener group			X									
Coalition membership			X	X		X						X
Operations and processes												
Communication						X						X
Decision making	X					X		X				
Conflict management			X			X		X				
Benefits and costs	X	X				X		X	X			
Climate	X					X			X			
Leadership	X			X		X	X				X	X
Staffing	X		X	X		X					X	X

	Butterfoss et al. (1996)	Chinman et al. (1996)	Center for Substance Abuse and Prevention (1998)	Fawcett et al. (1997)	Florin et al. (1993)	Kegler et al. (1998a, 1998b)	Kumpfer et al. (1993)	Mayer et al. (1998)	McMillan et al. (1995)	Nelson (1994)	Reininger et al. (1999)	Rogers et al. (1993)
Structures												
Organizational structure						X						
Formalization						X		X			X	X
Pooled resources				X		X						X
Member engagement												
Satisfaction	X			X		X	X					X
Participation	X	X		X		X		X				
Commitment									X			X
Assessment and planning	X		X	X	X	X	X	X				
Implementation of strategies			X	X		X		X			X	
Community change outcomes				X				X		X	X	
Health and social outcomes			X	X								
Community capacity						X						

[a] In several of these studies, the unit of analysis was at the subcommittee level.

[b] Methods codes: S: member survey, I: interviews, D: document review/archival records, 0: observation, L: logs, F: focus groups.

Table 7.3 lists the number of coalitions studied and the major data collection methods employed: surveys of members or the general population, interviews with key informants, review of documents and/or archival data, observation, logs, and focus groups. The table also lists the major constructs in the theory and identifies which of the studies examined each construct.

Stages of Development

Researchers and practitioners agree that effective coalitions develop over a period of time. In Table 7.1, Proposition 1 states that coalitions develop in stages and recycle through these stages as new members are recruited, plans are renewed, and new issues are added. Thus, the process of building and maintaining coalitions is not linear, but rather cyclical, with coalitions returning to earlier stages as community situations dictate (McLeroy et al., 1994). The naming of those stages and specific tasks that should be accomplished at each stage differ. Several different series of stages have been proposed, including formation, implementation, maintenance, and outcomes (Butterfoss et al., 1993); planning, intervention, and outcomes (Fawcett, Paine, Francisco, & Vliet, 1993); and mobilizing, establishing structure and function, building capacity for action, planning for action, implementation, refinement, and institutionalization (Florin, Mitchell, & Stevenson, 1993).

Researchers and practitioners agree that the following tasks must occur at some stage to ensure coalition effectiveness: recruiting and mobilizing coalition members, establishing organizational structure, building capacity and planning for action, selecting and implementing strategies, evaluating outcomes, refining strategies and approaches, and institutionalizing those strategies or the coalition itself (McLeroy et al., 1994). McLeroy and his colleagues agree that at each stage, certain factors enhance coalition function and progression to the next stage (Proposition 2). Finally, those who study or work in coalition settings agree that to accomplish their objectives, attention must be paid to maintaining coalitions and constantly recruiting new organizations in order to increase their impact (Kreuter, Lezin, & Young, 2000; Kaye & Wolff, 1995; Dowling et al., 2000; Butterfoss et al., 1998a). Most of the research to date focuses on the early stages of coalition development; consequently, less is known about the factors related to coalition success in the later stages of development (Table 7.3).

Community Context

Coalitions are embedded in communities, and as a result, factors in the community environment can have a significant impact on a coalition (Butterfoss et al., 1993; McLeroy et al., 1994; Lasker, Weiss, & Miller, 2000). Proposition 3 asserts

that coalitions are heavily influenced by contextual factors throughout all stages of development. Several studies support this proposition. For example, Reininger, Dinh-Zarr, Sinicrope, and Martin (1999) discuss tension and mistrust between groups and how the lack of trust affected a coalition. Others have documented the impact of political and administrative contexts on coalitions (Dill, 1994; Clark, Baker, & Chawla, 1993; Nelson, 1994). Kegler et al. (1998a) noted the impact of tobacco-related politics on tobacco control coalitions in several stages of coalition development, from recruitment in the formation stage to the types of activities conducted in the maintenance stage. History of collaboration is widely cited in the wisdom and theoretical literature as another contextual factor that can affect the formation of collaborative relationships, including coalitions (Gray, 1989), with positive norms for collaboration increasing the likelihood of future successful collaboration. Additional contextual factors that affect coalitions include social capital (see Chapter Nine, this volume), trust between segments of a community, geography, and community readiness (Wolff, 2001).

Lead Agency/Convener Group

Proposition 4 states that coalitions usually form when a lead agency or convener group responds to an opportunity, threat, or mandate. Propositions 5 and 6 state that a lead agency begins coalition formation by recruiting a core group of community leaders and providing initial support for the coalition. The lead agency or convener is the organization that has the vision or mandate to mobilize community members initially to form a coalition focused on a specific issue of concern. This organization may or may not have written a grant or otherwise procured funds for coalition operation. The convener does, however, accept responsibility to host an initial meeting and recruit prospective partners. The lead agency may also provide physical space for coalition operation and a part- or full-time staff person to manage the initiative.

Although the literature concerning coalition practice acknowledges that the convening agency must have sufficient organizational capacity, commitment, leadership, and vision to build an effective coalition, research on these and other factors that lead agencies should possess is sorely lacking (Butterfoss et al., 1993). In one of the few studies comparing coalitions with differing reasons for initiation, Mansergh, Rohrbach, Montgomery, Pentz, and Johnson (1996) found that researcher and community-initiated coalitions were similar in terms of perceived coalition efficiency, outcome efficacy, benefits of involvement, and interagency collaboration. The only difference between the two was that action committee effectiveness ranked higher in the researcher-initiated coalition. The researchers concluded that factors other than the impetus for initiation might be more critical

for coalition effectiveness. A related area with little research is whether coalitions develop anew or simply evolve from other preexisting coalitions and networks in a community (Herman, Wolfson, & Forster, 1993; Nezlek & Galano, 1993).

Coalition Membership

Limited research has focused on the defining characteristics of the founding members of community coalitions. Common wisdom holds that previous experience with the health issue or experience with coalitions increases the commitment of these core members. Experience shows that members participate in coalitions with varying levels of intensity—what Brager et al. (1987) described as active, occasional, and supporting participants. Brager et al. noted that flexible participation is essential when working with volunteers.

Composition of the core group may affect its ability to engage a broad cross section of the community. Propositions 6, 7, and 8 state that the core group must recruit community gatekeepers, those committed to the issue, and a broad constituency of diverse groups and organizations. This pooling of diverse views, perspectives, and resources is one of the hallmarks of coalitions and gives them the potential to solve problems that individual agencies could not address alone. Effective coalitions make concerted efforts to recruit memberships that are diverse in terms of expertise, constituencies, sectors, perspectives, and backgrounds. In addition, funders are often concerned about increasing the diversity of coalition members as evidenced by the recent focus on reducing health disparities in such efforts as the Centers for Disease Control and Prevention's REACH initiative.

Coalition Operations and Processes

Coalitions must fulfill certain basic functions such as making decisions, communicating, and managing conflict (Propositions 9 through 11). Indeed, much of the research on coalitions has focused on internal processes and operations, with the assumption that effective internal functioning is necessary for progress toward achieving goals (see Table 7.3). The quality of interactions among member networks is demonstrated by the frequency and intensity of contacts and the benefits that members receive from them, such as emotional or tangible support and access to social contacts (Israel, 1982). Research suggests that the extent of regular contacts among community members can foster cooperation (Putnam, 1993). Similarly, members can be empowered by building networks and experiencing positive social relationships (Kumpfer, Turner, Hopkins, & Librett, 1993). Research has also suggested that frequent and productive communication and networking among members increase satisfaction, commitment, and implementation of strate-

gies (Rogers et al., 1993; Kegler et al., 1998b). Similarly, staff members are most satisfied and committed when good communication exists between members and themselves (Rogers et al., 1993). Members who report an increase in the number and type of linkages with outside organizations tend to participate more in the coalition (Butterfoss et al., 1996; Mayer et al., 1998). Coalition studies have also examined decision making and shown that the influence that participants have in making decisions is vital to a partnership. In turn, influence in decision making is related to increased satisfaction and participation and reporting of more positive benefits (Butterfoss et al., 1996; Mayer et al., 1998).

Another internal process that must be initiated to ensure smooth internal functioning is conflict management. Mizrahi and Rosenthal (1992) argue that conflict is an inherent characteristic of partnerships. Conflict may arise between the partnership and its priorities for social change or among partners concerning issues such as loyalty, leadership, goals, benefits, contributions, and representation. Conflict has been shown to lead to staff turnover, avoidance of certain activities, and difficulty in recruiting members (Kegler et al., 1998a). Conflict transformation is the process whereby resolution of conflict strengthens the coalition and builds capacity. Research shows that conflict transformation results from effective coalition planning and contributes to coalition goal attainment (Mayer et al., 1998).

Proposition 12 posits that perceptions of benefits must outweigh perceived costs to ensure ongoing participation in assessment, planning, and resource development. The literature points out several examples in which member costs and benefits were related to the process of engagement. In general, providing incentives and reducing costs increased member participation in voluntary associations (Wandersman, Florin, Friedmann, & Meier, 1987; Prestby et al., 1990) and in coalition committees, especially during the formation and early maintenance stages (Butterfoss et al., 1996; Butterfoss et al., 1998a; Chinman et al., 1996; Mayer et al., 1998). The wisdom literature is consistent in encouraging coalition leaders to provide incentives for continued participation (Kaye & Wolff, 1995).

Another factor related to member engagement is the organizational climate of the coalition. Proposition 13 states that positive relationships among members are likely to create a productive coalition environment or climate. Organizational climate refers to members' perceptions of the personality of an organization and is typically measured by ten factors: cohesion, leader support, expression, independence, task orientation, self-discovery, anger and aggression, order and organization, leader control, and innovation (Moos, 1986). Organizational climate characteristics (such as leader support and leader control) are related to satisfaction with the work, participation in the partnership, and perceived costs and benefits (Butterfoss et al., 1996), as well as increased implementation of action plans (Kegler et al., 1998b). Researchers have found that task focus is related to

satisfaction (Kegler et al., 1998b) and psychological and organizational empowerment (McMillan et al., 1995). Similarly, the wisdom literature points out the value of promoting positive group climate and relationships among members (Kaye & Wolff, 1995; Dowling et al., 2000).

Leadership and Staffing

Propositions 14 and 15 emphasize the importance of leadership and staffing in coalitions. Without these, coalitions are unlikely to move beyond the initial steps in the formation stage of development. Coalition leaders and staff organize the structure 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. 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. Thus, a common approach to leadership in coalitions is the formation of steering committees composed of leaders from action-focused work groups. Empirical research on coalitions shows a consistent relationship between leader competence and member satisfaction (see Table 7.3).

Leadership is complex, and researchers have examined many facets in addition to member perceptions of leader competence (Glidewell, Kelly, Bagby, & Dickerson, 1998). For example, Kumpfer et al. (1993) studied leadership style and found that an empowering style was related to action plan quality. Butterfoss and colleagues (1996) found that leader support and control were related to several member-related outcomes but not to quality of the action plan. Reininger et al. (1999) explored how leaders' being indigenous or not affected coalitions. In a study of ten rural coalitions formed to prevent drug abuse, Braithwaite, Taylor, and Austin (2000) noted that the most successful coalitions had strong leadership and a commitment to a common goal. Others have found that the ability of a coalition to develop a clear and shared vision, a likely result of good leadership, is associated with success (Kegler et al., 1998a; Center for Substance Abuse and Prevention, 1998).

In many coalitions, leadership and staffing are intertwined, with paid staff fulfilling many leadership functions, such as setting agendas and facilitating meetings. Staff often support the coalition, encourage membership involvement, and build community capacity (Sanchez, 2000). Some research suggests that coalitions with staff who play a supportive role for the coalition rather than a visible leadership role have higher levels of implementation (Kegler et al., 1998a).

Several studies of coalitions have examined how staffing is related to intermediate indicators of effectiveness, including member-related outcomes, action

plan quality, resource mobilization, and implementation of planned activities (see Table 7.3). Two of these studies demonstrated relationships between staff competence and member satisfaction (Rogers et al., 1993; Kegler et al., 1998b). Furthermore, Butterfoss and colleagues (1996) found an association between staff competence and member benefits. Kegler et al. (1998b) also found a positive relationship between staff time devoted to coalition efforts and the amount of resources mobilized and level of implementation of planned activities, thereby lending support to the need for paid staff with sufficient time to devote to the coalition. Minimal or nondisruptive staff turnover has also been linked to positive outcomes (Center for Substance Abuse and Prevention, 1998; Kegler et al., 1998a).

Coalition Structures

Proposition 16 asserts that coalitions are more likely to engage members, pool resources, and assess and plan well when they have formalized rules, roles, structures, and procedures. Formalization is the degree to which rules, roles, and procedures are precisely defined. Examples of formal structures are committees, written memoranda of understanding, by-laws, policy and procedures manuals, clearly defined roles, mission statements, goals, objectives, and regular reorientation to the purposes, goals, and procedures of collaboration (Butterfoss et al., 1993; Goodman & Steckler, 1989). 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 (Goodman & Steckler, 1989). Research shows that the existence of formal structural elements such as by-laws, agendas, and minutes is related to organizational commitment (Rogers et al., 1993). In addition, structuring a coalition to focus on action, such as creating task forces or action teams, is associated with increased resource mobilization and implementation of strategies (Kegler et al., 1998b).

Pooled Member and External Resources

A major premise underlying the widespread adoption of coalitions to address community problems is that working together creates a synergy that enables individuals and organizations to accomplish more than they could achieve independently (McLeroy et al., 1994). Proposition 17 in Table 7.2 asserts that this pooling of resources ensures more effective assessment, planning, and implementation of strategies. Resource sharing also gives coalitions unique advantages over less collaborative problem-solving approaches. Lasker, Weiss, and Miller (2000) pointed out that much of the research on coalitions focuses on internal functioning, but does not explicate the pathways through which collaboration increases the likelihood of

achieving outcomes over traditional single-agency interventions. They proposed that synergy is the mechanism through which partnerships gain advantage over more traditional, less collaborative approaches. Furthermore, they hypothesized that synergy is the proximal outcome linking partnership functioning to achieved outcomes.

Resources, defined broadly, are one of the major determinants of synergy as conceptualized by Lasker and colleagues. Coalition members are the greatest asset in a coalition-based initiative. They bring energy, knowledge, skills, expertise, perspectives, connections, and tangible resources to the table. The pooling of these diverse resources enables coalition members to achieve together what they could not accomplish alone. Research has shown that staffing and structure of coalitions are related to resource mobilization, which is related to effective implementation of coalition strategies (Kegler et al., 1998b). Successful resource mobilization allows for more creative solutions and more practical, comprehensive approaches (Lasker et al., 2000).

Resources from outside the membership and the community are also helpful, as they often fund staff and pay costs associated with implementing planned activities. Such resources relieve some of the burden that communities with limited financial resources face. External resources may also provide additional expertise, meeting facilities, mailing lists, referrals, additional personnel for special projects, grant funding, loans or donations, equipment, supplies, and cosponsorship of events (Chavis, Florin, Rich, & Wandersman 1987; Prestby & Wandersman, 1985; Braithwaite et al., 2000).

Member Engagement

Member engagement is best defined as the process by which members are empowered and develop a sense of belonging to the coalition. Positive engagement is evidenced by commitment to the mission and goals of the coalition, high levels of participation both in and outside coalition meetings and activities, and satisfaction with the work of the coalition. Among the factors that enhance engagement are that the perceived benefits of membership outweigh the costs and that members experience a positive coalition environment (Propositions 12 and 13; Butterfoss et al., 1996).

Members who experience more benefits than costs participate more fully and are more satisfied with the work of the coalition. Proposition 18 asserts that satisfied and committed members will have higher levels of participation than less satisfied members. Research supports this assertion and consistently demonstrates that satisfied and committed members will also participate more in the work of

the coalition (Butterfoss et al., 1996, 1993; Roberts-DeGennaro, 1986; Rogers et al., 1993; Mayer et al., 1998). Although satisfied and highly participating members are valued, the same studies failed to support the hypothesis that these factors lead to desired intermediate outcomes (for example, producing high-quality action plans) or long-term outcomes (reducing ATOD [alcohol, tobacco, and other drug] use). However, case examples of coalitions exist in which intermediate and long-range successes can be attributed to the commitment and satisfaction of their members (Butterfoss et al., 1998a).

Assessment and Planning

Achieving a coalition's goals involves assessing the situation and deciding what action to take. A coalition-based initiative, such as one that is a part of a state or national program, usually engages in an extensive assessment and planning process that can last as long as two years and is typically followed by an implementation phase of three to five years. Several coalition studies have examined the quality of the action plans produced by these types of coalition efforts. Analyses of activities selected by coalitions have shown a tendency toward activities that promote changes in awareness (Florin et al., 1993). Kreuter and colleagues (2000) note that despite a strong emphasis on needs assessment, written objectives, and logic models that depict cause-and-effect relationships between interventions and outcomes, many collaborative efforts fail to produce rigorous plans. Quality plans, associated with competent staffing, leadership, and resource mobilization, contribute to successful implementation (Butterfoss et al., 1996; Kumpfer et al., 1993; Kegler et al., 1998b). Proposition 19 states that successful implementation of strategies is more likely when comprehensive planning and assessment occur.

Implementation of Strategies

Successful implementation depends on numerous factors such as sufficient resources, completion of tasks on schedule, fidelity to the planned intervention strategies, and a supportive, or nonturbulent, organizational and community environment. Assuming the interventions 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 (Green, 2001; Cameron, Jolin, Walker, McDermott, & Gough, 2001).

Focusing on best practices or evidence-based interventions may minimize the extent to which coalitions engage in community awareness activities. This tendency to focus on easier interventions and quick wins may help to maintain member interest, but it is unlikely to lead to more valued outcomes and may help explain why some coalition-based efforts are not able to achieve systems or health outcomes change (Kreuter et al., 2000). Most researchers and practitioners agree that effective health promotion efforts require change at multiple levels, including environmental and policy change (McLeroy, Bibeau, Steckler, & Glanz, 1988). Goodman, Wandersman, Chinman, Imm, and Morrisey (1996) further suggest that as coalition interventions become more complex and focus less on individual behavior change, the assessments of such coalitions should focus across multiple levels and take community readiness into account. Proposition 20 emphasizes the importance of implementing interventions at multiple levels in order to create change in community policies, practices, and environments.

As coalition interventions become more complex and focus less on individual behavior change, the assessments of such coalitions should focus across multiple levels and take community readiness into account.

Community Change Outcomes

By implementing interventions at multiple levels, coalitions are able to create change in communities that can reduce risk factors and increase protective factors. Fawcett and colleagues (1997) categorized these into changes in programs, changes in policies, and changes in practices of community agencies, businesses, and government entities. Coalitions can also create change in communities by developing the skills of individuals, increasing the sense of community, and providing new perspectives on community problem solving for residents. At other levels, coalitions can create changes in opportunities for civic participation, linkages between organizations, and the physical and social environment of a community (Kegler, Twiss, & Look, 2000). The Community Coalition Action Theory posits that coalitions that are able to create these types of community changes are more likely to increase community capacity to address other issues of concern and to realize their long-term goals (Proposition 21).

Health and Social Outcomes

Proposition 22 states that the ultimate indicator of coalition effectiveness is improvement in health and social outcomes. Several recent reviews have been

published documenting only modest evidence of effective collaborative partnerships. Roussos and Fawcett (2000) reviewed thirty-four studies that represented 252 collaborative partnerships. The authors categorized the studies into those that provided evidence for more distant population-level outcomes, communitywide behavior change, and environmental change. The review stated that research is insufficient to make strong conclusions about the impact of partnerships on population-level outcomes largely due to design issues (most of the research consists of case studies). With respect to communitywide behavior change, Roussos and Fawcett concluded that partnerships could make modest contributions. Strongest evidence existed for partnerships' contributions to environmental change, broadly defined to include changes in programs, services, and practices.

Similarly, Kreuter and colleagues (2000) reviewed sixty-eight published descriptions of coalitions and consortia with evaluation protocols in place and found only six examples of documented health status or systems change. Numerous reasons have been discussed in the literature as possible explanations for the disappointing findings associated with collaborative initiatives (Roussos & Fawcett, 2000; Mittelmark, 1999; Kreuter et al., 2000; Berkowitz, 2001). For example, design issues and secular trends make the detection of community-level change challenging. Also, some note that coalitions tend to focus on quick wins and awareness activities. These strategies alone will not lead to significant changes in systems or health status.

Community Capacity

In addition to coalition outcomes associated with health or social issues, another set of outcomes is associated with increases in a community's capacity to solve problems (see Chapter Eight, this volume). Proposition 23 asserts that coalitions can develop community capacity, which has been discussed as both a possible prerequisite to community problem solving and an outcome of community health promotion efforts (Goodman et al., 1998). It includes dimensions that coalitions can theoretically affect (positively or negatively) such as participation and leadership, networks of individuals and organizations, skills and resources, and sense of community. Crisp, Swerissen, and Duckett (2000) identify the development of partnerships as one of four distinct approaches to building capacity, arguing that two-way communication between groups that previously have not worked together can result in more resources for planning and implementation. Little coalition research has focused on outcomes associated with community capacity, although current evaluation research is examining these issues (Norton, Kegler, & Aronson, 2000).

Application of the Model: Consortium for the Immunization of Norfolk's Children

In 1992, the Centers for Disease Control and Prevention's National Immunization Program selected Norfolk, Virginia, as a site to demonstrate how a community coalition could improve immunization rates for children under two years of age. Norfolk was selected due to its low immunization rates (49 percent of two-year-olds in 1993), ethnic diversity, and public, private, and military health care systems. By helping citizens develop and implement comprehensive, effective strategies, the Consortium for the Immunization of Norfolk's Children (CINCH) realized its goals and increased childhood immunization rates by 17 percent. This case example shows how CINCH followed the community coalition model presented in Figure 7.1.

Stages of Development

CINCH was in the formation stage for approximately six months. During this time, underimmunization was defined as a community problem, coalition members were recruited, and mission, rules, and roles were specified. The members were also trained during this stage. During the next stage, maintenance, coalition membership was sustained, and actual work began. Coalition members assessed needs, collected and analyzed data, developed a plan, initiated and monitored strategies, and supported and evaluated their group process. After three years, the coalition expanded geographically to include the Hampton Roads region and was renamed the Consortium for Infant and Child Health (with the same acronym). CINCH subsequently recycled through formation and maintenance stages as it engaged in a new recruitment and needs assessment process. In February 1997, CINCH released the *Report on the Health of Children in Hampton Roads.* After engaging in a priority-setting process, the coalition decided to focus on immunization and add perinatal issues (such as low birthweight, teen pregnancy, and infant mortality) to its mission. CINCH collaborated with and reenergized an existing perinatal council and eventually relinquished responsibility for this health issue (institutionalization stage).

In March 2000, the *Report on the Health of Children in Hampton Roads* identified childhood asthma as the number one diagnosis for hospital admission, as well as emergency room and physician visits in the region. CINCH then launched an asthma work group and applied for and received funding from the Robert Wood Johnson Foundation in 2001. The coalition recruited new members with asthma

expertise and concern, and conducted an asthma-related needs assessment. CINCH recycled through the developmental stages three times during eight years as new issues arose, strategies were revised, and many new members were recruited.

Lead Agency/Convener Group

The Center for Pediatric Research, a joint program of a children's hospital and medical school, convened CINCH and serves as its lead agency. Although the center was new, the region valued collaborative efforts and embraced the concept of coalition building as proposed by the center staff, who were experienced with this strategy. The staff recruited a core group of organizations, which then recruited fifty-five service agencies; academic, civic, and faith-based institutions; health care providers; and parents.

Coalition Membership

Members from various grassroots and professional organizations provided diversity in age, occupation, race, and ethnicity. They willingly put aside differences in order to share responsibility for all of the community's children. Relying on new knowledge and core values, the coalition developed its mission to improve immunization rates for children under two years of age. This common mission and commitment to community improvement helped members overcome barriers that often stall new coalitions, such as lack of direction or turf battles (Kaye & Wolff, 1995; Butterfoss et al., 1996).

Coalition Operations and Processes

Members reported that they had either a great degree of influence (74 percent) or some influence (26 percent) in determining policies and actions of the consortium. When conflict arose, 82 percent reported that they were able to resolve it effectively. Content analysis of meetings showed that activities were balanced among tasks of orienting members, assessing needs, planning and revising coalition structure and functions, sharing information, and developing and evaluating products or services. Members evaluated meetings to identify successful elements (Goodman & Wandersman, 1994) and rated work group and general meetings as 88 percent and 92 percent effective, respectively. Leaders and staff debriefed about barriers to effective meetings and recommended improving agendas, attendance, tardiness, participation, leadership, and grassroots representation.

Leadership and Staffing

From the outset, CINCH had a full-time staff coordinator and part-time administrative assistant. The leaders of the coalition were community members who were elected by the membership. The steering committee, which consisted of coalition and work group chairs and vice chairs, as well as staff and other nonvoting honorary members, prepared the job description and advertised, interviewed, and hired the coalition coordinator. The coordinator had previously served as a coalition member and now worked for the coalition.

Leaders were sensitive to member needs by allowing varying levels of participation during each coalition stage. They reduced burnout and maximized resources by recognizing that some members are better planners and others are better doers. Staff supported members by preparing draft documents, minutes, rosters, meeting reminders, and mailings. They helped leaders set agendas, run effective meetings, and plan strategies to promote member retention. To engage members, lead agency staff provided training on a variety of issues related to immunization.

Membership and commitment may waiver as a coalition realizes that it takes time to accomplish its goals. To keep members involved, CINCH participated in health fairs, marches, and other community health efforts. Leaders worked to maximize member participation. Meetings provided opportunities to cultivate and renew relationships and celebrate incremental achievements. Members received written reminders and telephone calls about meetings and follow-up when they were absent. Member surveys measured satisfaction and participation and defined areas for improvement.

Coalition Structures

Members developed written rules of operation, criteria for membership, and roles for members, leaders, and staff. CINCH also developed work groups focused on specific tasks and populations that complemented each other. Chairs and vice chairs were elected for work groups and the coalition at large.

Pooled Member and External Resources

Each member brought individual skills to the coalition, but also represented an organization that brought resources to the table. Member organizations contributed financially or in-kind to implement strategies, since grant funds were earmarked only for research. When personal agendas were put aside, resources were

more effectively pooled. Work group members invited health department and hospital directors, as well as professional and voluntary agencies from neighboring cities, to join them at the table. As previously competitive organizations learned the value of collaborating to accomplish tasks, the level of trust improved.

Funding restrictions prompted CINCH to develop community support for its activities and increased the likelihood of sustaining its efforts beyond the grant period. Private foundation funding enabled the coalition to hire an outreach coordinator, conduct a media campaign, and implement key strategies. In-kind contributions from CINCH members included the printing of posters, flyers, and brochures; arranging satellite teleconferences; and contributing parent incentives. In this way, the resources from the federal grant, local foundation, and member organizations complemented each other and created synergy.

Member Engagement

Training, defined roles, and ongoing contact with participating institutions were essential for member retention. Member involvement was bolstered by achievement of objectives and positive results. A clear vision of leadership and commitment to a quality process kept members interested. CINCH also made good use of each member's linkage with others. Members constantly recruited others, who provided resources or represented the priority population. New recruits stimulated creativity and renewed effort among founding members. Member surveys showed that 86 percent were satisfied with the work of the coalition (Butterfoss et al., 1998a). Average attendance over 130 CINCH meetings was 59 percent, considered acceptable by coalition research (Prestby & Wandersman, 1985).

Assessment and Planning

Following formation, CINCH's major tasks focused on needs assessment, data collection, analysis, feedback, and plan development. First, work group members participated in a needs assessment to diagnose local causes of underimmunization. Parent focus groups, patient exit interviews, and household and health care provider surveys were planned and conducted (Houseman, Butterfoss, Morrow, & Rosenthal, 1997; Butterfoss et al., 1998a).

Staff conducted workshops to train work group members to develop quality action plans. Once trained, each work group used data to identify a prioritized set of needs related to their priority group (for example, parents, health care providers). Goals, objectives, and strategies were developed to address each identified community need. The groups considered the strengths of their community and

the resources they could draw on to implement various strategies. Linkages among community agencies were identified, and evaluation of strategies was planned. Work group leaders combined the individual plans into one overall two-year strategic immunization plan that focused on parent and provider education and support for at-risk families, thereby increasing access to immunizations and improving immunization delivery. The intrinsic negotiation involved in this process cemented relationships among group leaders and strengthened internal support for the plan. The planning process led to the creation of a steering committee that still meets regularly to share successes and challenges. Members also learned that planning is a continuous process and later developed timelines, management plans, and budgets.

Implementation of Strategies

During this time, new strategies were initiated, and others were maintained and monitored. Work groups collaborated on strategies and responsibilities and even merged to streamline operations. Some activities were initiated and finished quickly, while others were not achieved until after funding ended. CINCH had an impact on the Norfolk community by effectively implementing sixty-one of seventy-nine planned strategies (77 percent). An evaluation component for each strategy helped members decide whether it was based on need, implemented as planned, and could be improved. Action plans were revised annually.

Community Change and Health Outcomes

CINCH accomplished some of its more difficult objectives such as Women, Infants and Children (WIC) linkage, physician practice assessment and feedback, hospital birth reminder systems, and legislative action. Members not only directed the course of community events, but also wielded power to influence larger institutions such as hospitals and the state legislature. Although any change in immunization levels for two-year-olds could not be attributed to CINCH alone, rates rose from 48 percent in 1993 to 66 percent in 1996 (Morrow et al., 1998). Higher rates were reported among hospital and military clinics.

Community Capacity

Through training and practice in leadership, meeting facilitation, needs assessment, and planning, coalition members developed skills that improved their participation and could be generalized to other civic areas. Members and staff also

provide technical assistance to other local partnerships that deal with tobacco use, child safety, and school health. CINCH collaborated with projects focused on case management, community policing, and neighborhood improvement. In addition, it fostered new state contracts and federal grants that promote environmental change. A contract between CINCH's lead agency and the state health department was forged to develop and manage a state immunization coalition, Project Immunize Virginia, which used the CINCH model to help other localities develop community partnerships to advocate for immunizing children across the state. Under an Association of Teachers of Preventive Medicine grant, the Coalition Training Institute was established in Norfolk in 1995 to train key health agency staff who coordinated immunization coalitions in eighty-eight urban, state, and territorial sites (Butterfoss, Webster, Morrow, & Rosenthal, 1998b).

Strengths and Limitations of the Theory

Any new theory is bound to have strengths and limitations and must be open to constructive criticism from practitioners and researchers who have a stake in the related work.

Any new theory is bound to have strengths and limitations and must be open to constructive criticism from practitioners and researchers who have a stake in the related work. The Community Coalition Action Theory is long overdue. The benefit of its delayed appearance, however, is that it is grounded in almost two decades of practice and research. Perhaps one reason that this theory has not been developed before is that the complexity of community coalitions and the multifaceted nature of their work overwhelm researchers and practitioners alike. The model that describes our theory is complex and takes into account the diverse factors that influence the formation, implementation, and maintenance of coalitions.

Although community coalitions are found in a variety of settings that range from urban to rural, the empirical research and subsequent findings have focused mostly in the area of alcohol, tobacco, and other drug abuse prevention. This is not surprising when one considers that the highest level of foundation and governmental agency funding for coalition work has centered on these health issues. Although coalitions exist for many other health issues, including cardiovascular disease, human immunodeficiency virus and acquired immunodeficiency syndrome, unintentional injury prevention, and immunization, large-scale evaluative research findings have not yet been reported for these issues. Similarly, much of the research that forms the basis of the Community Coalition Action Theory is

from studies conducted in the early 1990s and tends to focus on coalition functioning and intermediate indicators of effectiveness, such as satisfaction, participation, action plan quality, and implementation. Because of the widely acknowledged difficulty in attributing health outcome change to community collaborative efforts, much of the more recent research uses case study methodology. Although very informative, case study findings are difficult to generalize from and focus less often on associations among constructs.

The constructs that are used in the Community Coalition Action Theory are informed by research, yet we have speculated on how they interrelate with one another. We have used a set of propositions to help us order the constructs in a logical sequence and develop reciprocal or directional linkages among them. But the research evidence does not totally ensure that these assumptions are correct. In addition, we have not weighted each variable in our model. How important are coalition processes, for example, as compared to coalition structures? The model does not quantify the resources needed to implement successful strategies or the level of member engagement that leads to effective assessment and planning. Further research should help clarify the constructs, their importance to the whole, linkage patterns, and directionality.

The model is complicated by the complexity of each of the constructs. For example, the operation and processes construct includes communication, decision making, and conflict management. All of these are likely related to organizational climate, but which are more important and in what situations and stages? Similarly, we identify several dimensions of community context and assert that context affects each construct in the model and each stage in coalition development. Yet much research remains to be done to understand how distribution of power in a community, for example, affects what organization serves as the lead agency, who makes up the core group, and whose needs are assessed.

Numerous types of collaborative relationships exist. We focused on community coalitions and defined them as long-term community structures that enable organizations and individuals to work collaboratively to address community problems. We were careful not to cite research done with other types of collaborative initiatives because in the past, careful distinctions have not been made when summarizing "coalition" findings. Different types of collaborative partnerships (for example, state level, grassroots, mandated, and voluntary) may function differently and be influenced by different factors in each stage of coalition development. Stages of coalition development may also need to be conceptualized differently for different types of partnerships. For example, a grassroots citizens' group formed to keep a landfill out of a neighborhood may not need to institutionalize anything once the landfill is sited elsewhere.

Future Directions

With the advent of evidence-based medicine and outcomes-based interventions, coalitions have recently been criticized as not meeting expectations for success (Green, 2000). Given the tremendous infusion of resources, both monetary and in donated volunteer time, some see this criticism as well deserved. The overall evidence for positive coalition outcomes is lacking; however, traditional scientific methodology may not be adequate to capture the outcomes of these complex collaborative organizations (Berkowitz, 2001). For example, we cannot underestimate the amount of time that it takes to create and sustain viable coalitions or the difficult task of identifying and implementing best practices. Similarly, evaluators and coalitions are often reluctant to accept qualitative methods of evaluation or to identify realistic intermediate- and long-term outcomes. Finally, communities may not always understand the long-term benefits and unintended positive outcomes of coalitions. However, we need to be careful lest we throw the baby out with the bathwater by criticizing coalitions for not achieving measurable outcomes.

Evaluators are beginning to argue for more research focusing on what coalitions contribute to community-based interventions above and beyond more traditional approaches (Lasker et al., 2001; Berkowitz, 2001; Butterfoss, Cashman, Foster-Fishman, & Kegler, 2001). For example, do coalition approaches 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 types of interventions than traditional public health and social service agencies, such as policy or media advocacy efforts? A logical future direction for research on coalitions, and this theory in particular, would be to document and describe what Lasker and colleagues term *partnership synergy.*

Unfortunately, community coalitions are in the same situation as almost all other community-level initiatives in facing the challenges associated with documenting long-term outcomes and attributing resulting changes to the initiative. Our contention is that by strengthening the theoretical base and developing a model of action for community coalitions, we will advance this area of scientific inquiry. We encourage theoreticians to test the logic of this model. We challenge researchers to use the model, at both the case study and large-scale level, to field-test our assumptions and advance the understanding of which coalition characteristics and interactions are most likely to fuel goal attainment. Finally, we ask practitioners, the front-line coalition pioneers, to determine whether this model is useful to increase local support and capacity for further coalition development.

This theoretical model is a starting point; we welcome all contributions that improve its validity, reliability, and utility.

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