PART ONE

MAKING THE CASE FOR COALITIONS AND PARTNERSHIPS

CHAPTER ONE

Historical Perspective of Coalitions

Americans of all ages, all stations of life, and all types of disposition are forever forming associations. . . . In democratic countries, knowledge of how to combine is the mother of all other forms of knowledge; on its progress depends that of all others.
—Alexis de Tocqueville, 1835, from Heffner, 2001

The concept of building coalitions to improve the human condition is hardly new. The collaborative work essential to the success of modern coalitions in promoting health and preventing disease has existed since the beginning of human history. This chapter outlines an abbreviated chronicle of the key approaches and notable individuals who shaped the ideals of community participation, community organizing, and community development. Unless we give credit to these foundations, we will not share the rich understanding of the roots that make working within coalitions an effective strategy for improving health.

COOPERATION AND SETTLEMENT IN EARLY AMERICA

When early indigenous people first recognized that hunting and gathering could be improved by working together in groups to increase their store of food, the ideologies of cooperation and collaboration were born. The tasks were usually divided along gender lines, with males being responsible for hunting and providing shelter and protection, while women focused on planting, gathering, homemaking, and child-rearing. People understood the necessity of matching tasks to skill sets and relying on cooperation. Even when people began to live in settlements, environments were often harsh and demanded that people band together for survival.

As we approach the celebration of the 400th anniversary of America's settlement in Jamestown, Virginia, in 1607, archeological findings indicate that these early pioneers relied on each other and indigenous Indian tribes, such as the Powhatan, to procure food and shelter. Those first years (1609–1610), called the "starving time,"

brought untold hardships from weather, insects, lack of potable water, disease, and the unfulfilled promise of needed supplies from England.[1] As in modern-day community relations, conflicts emerged and "the Indians whose succor spared Jamestown more than once had cause to regret their generosity" (Billings, 1990, p. 5). They became embroiled in a losing struggle to maintain their cultural identity, setting the stage for tragic conflicts involving Native American–white relations for three centuries. Similar scenarios were repeated throughout the settlement of the United States, with a pattern of interdependence and cooperation among people to share resources and skills. However, that cooperative spirit was also characterized by conflict, as competition for resources arose. These early forays into cooperation gave way to more formal collaborative efforts in the form of associations, explored next here.

THE DEVELOPMENT OF ASSOCIATIONS

As the pioneering spirit and character of the new United States emerged in the next century, Benjamin Franklin came to believe that people who cooperated and volunteered together could accomplish great things. The ultimate networker, in 1727, he organized a group of friends to engage in a structured discussion group called the Junto, whose members were drawn from diverse backgrounds and occupations (for example, printers, cabinet-makers, cobblers, merchants). They shared a spirit of inquisitiveness and a desire to improve themselves and their community. As their leader, Franklin insisted that their discussions and debates be "conducted in the sincere spirit of inquiry after truth, without fondness for dispute or desire of victory . . ." (Franklin, 1868, p. 60). Friday evening meetings were organized around a series of questions that served as a springboard for community action.

Always aware of his civic duty and mindful of the "greater good," Franklin used the Junto to help establish a volunteer firefighting association, mutual insurance companies, a public hospital, a network of night watchmen to improve security, and a circulating library. The Library Company, American Philosophical Society, and Pennsylvania Hospital still exist today (Independence Hall Association, 2005; Twin Cities Public Television, 2002). Later in his life, Franklin actively worked for the independence of America. He was elected to the Second Continental Congress, helped draft and signed the Declaration of Independence, and served as ambassador to the Court of Louis XVI in France, which led to the Treaty of Paris (1783). In his late seventies, he served as delegate to the Constitutional Convention and signed the Constitution. His last public act was to write an antislavery treatise in 1789.

Perhaps due to Franklin's influence, the French political thinker and historian Alexis de Tocqueville became fascinated with America's democratic system and its associations. De Tocqueville was convinced that democracy balanced liberty with equality, and community with concern for the individual. He wrote two volumes of *Democracy in America* after an eighteen-month visit to that country in 1831–32 to study its penal system. In writing *On the Use Which the Americans Make of Associations in Civil Life,* he expressed the idea that *association,* or the coming together of people for a common purpose, would bind Americans to an ideal of nation larger than selfish desires, a *civil society* (Heffner, 2001). According to de Tocqueville,

powerful individuals were more rare under conditions of equality in democratic societies; therefore, independent citizens needed to form associations in order to have influence (Brogan, 2005).

> *The power of the association has reached its highest degree in America. Associations are made for the purposes of trade and for political, literary, and religious interests. It is never by recourse to a higher authority that one seeks success, but by an appeal to individual powers working in concert* [p. 12].

De Tocqueville observed that Americans continually formed associations of every type to combat individualism and circulate new ideas (Cosentino, 1989).

> *Americans of all ages, all stations of life, and all types of disposition are forever forming associations. . . . In democratic countries knowledge of how to combine is the mother of all other forms of knowledge; on its progress depends that of all others* [p. 112].

De Tocqueville also correctly predicted that democracy would increase, and its rights and privileges would eventually be granted to women, Native Americans, and Africans (Brogan, 2005).

John McKnight (1995), known for his asset-based community development work, credits de Tocqueville with recognizing that both formal and informal associations provide the context for citizens to participate in their communities. De Tocqueville identified three steps in citizen problem solving: (1) Groups of citizens decide they have the power to identify a problem. (2) They decide they have the power to solve the problem. (3) They decide they themselves will become the key actors in implementing the solution. This process emphasizes the strengths, assets, and capacities of local citizens, and can only take place when community members are involved in local decision-making activities. In their landmark text, Kretzmann and McKnight (1993) elaborate further on the types of civic skills and social capital necessary to "build communities from the inside out" (p. 2). The following section illustrates how far-reaching that involvement can be when citizens engage in collaborative efforts to further social justice and community change.

COMMUNITY ORGANIZING FOR SOCIAL CHANGE: TRADE UNIONS, SETTLEMENT HOUSES, AND NEIGHBORHOOD AND COMMUNITY DEVELOPMENT

Succeeding generations of Americans continued to struggle for democracy and equality. "Americans have a history of organizing for social, economic, and political justice" (Bobo, Kendall, and Max, 2001, p. 4). In the 1800s, community-organizing movements

began, focused on improving Americans' health and quality of life. Feminists Lucretia Mott and Susan B. Anthony and abolitionists Frederick Douglass, William Lloyd Garrison, Sojourner Truth, and Harriet Tubman all worked with a vision toward the greater good.

Community organizing is a process by which disempowered people—most often with low to moderate incomes—are brought together to act in their common self-interest, while seeking the ideals of participatory democracy (Delgado, 1993). Community organizing encompasses many philosophies, approaches, issues, and constituencies in both rural and urban settings. It enables ordinary people to work for change and can have significant impact at the block, neighborhood, community, city, regional, state, and national levels (Fisher and Romanofsky, 1981). Three dominant approaches toward community organizing have emerged in the twentieth century: social work, political activism, and neighborhood maintenance–community development (Fisher, 1994).

Social Work Approach

The *social work approach* envisions community as a social organism with certain needs that must be coordinated to help the neighborhood remain viable. Community is built by gathering together existing social services, and lobbying for and delivering needed social resources. The organizer then promotes consensus and either enables the community to harness its resources or advocates on behalf of the community to obtain more services.

This approach was used in the social settlement movement in industrial cities of the East and Midwest in the first two decades of the twentieth century. Social settlements were "houses" set up in working-class neighborhoods by educated middle-class citizens to combat problems of poverty, housing, child labor, and tuberculosis. Input or support was not solicited from the people or communities they served. Philanthropic resources were offered in terms of education (classes in English and vocational skills), social services (legal and employment assistance, medical care and child care, recreational programs, and public baths), or lobbying (labor reform and public schools). For example, Hull House was founded by Jane Addams in Chicago in 1889 and offered services to more than 2,000 people per week.

> *So far as Settlement can discern and bring to local consciousness neighborhood needs which are common needs, and can give vigorous help to the municipal measures through which such needs shall be met, it fulfills its most valuable function.*
> —Addams, 1912, p. 320

Eventually, reformers like Florence Kelley, Julia Lathrop, and others who directed their efforts to the root causes of poverty joined Addams. They recruited trade unions, churches, benefit societies, social clubs, and individuals to lobby the Illinois legislature to protect immigrants from exploitation, limit the working ages and

hours of women and children, mandate schooling for children, recognize labor unions, and provide for sanitation and industrial safety.

In the 1920s and 1930s, labor militants like Eugene V. Debs created unemployment councils to raise demands for public relief. This working-class movement used a range of tactics, including local and national demonstrations, hunger marches, and petition drives. It supported community-based tenant organizations to fight evictions, farmers' unions to fight foreclosures, veterans' committees to demand bonuses, cultural associations among immigrants and artists, sharecroppers' unions among southern blacks, and in-plant organizing committees (Parachini and Covington, 2001).

The legacy of Eugene V. Debs and these early organizers led to the Social Security Act, New Deal programs, organizing across the working class, and forming associations like the Congress of Industrial Organizations (CIO) that ensured the right to organize, minimum wage, and the eight-hour workday for all (Bobo, Kendall, and Max, 2001).

Political Activist Approach

The *political activist approach* views the community as a political entity, not a social organism. The neighborhood is seen as a potential power base that can keep power, get more power, or build alternative institutions apart from powerful ones that already exist. The organizer's role here is to help the community understand and mobilize around a problem in terms of power. The political activist approach uses less consensus building than does the social work approach, because the neighborhood may be put into conflict with individuals, groups, or institutions that stand to lose power. This type of community organizing is also called *social action organizing* (Burghardt, 1987; Rothman and Tropman, 1995). Fisher describes these efforts as "grassroots based, conflict oriented, with a focus on direct action, and geared to organizing the disadvantaged or aggrieved to take action on their own behalf" (Fisher and others, 2005, p. 51).

One cannot talk about the political activist approach without referencing the soul of community organizing, Saul Alinsky, who emerged as an organizer in the late 1930s. Influenced by the militant labor movement of his time, in 1938, Alinksy organized the Back of the Yards Neighborhood Council (BYNC) in a working-class, ethnic neighborhood next to the slaughterhouses in Chicago. By building a strong coalition of the union, Roman Catholic parishes, small businesses, voluntary associations, and residents, BYNC got jobs and services from corporations, the political machine, and the federal government. BYNC eventually won victories on numerous issues such as child welfare, public school improvement, and neighborhood stabilization.

BYNC successes led to the formation of the Industrial Areas Foundation, which was backed by the Archdiocese of Chicago, the Congress of Industrial Organizations, and Marshall Fields and was the base of operations for Alinsky for the rest of his life. His collaboration with Fred Ross led to the formation of the Community Service Organization for Mexican American Workers in California, which trained César Chávez to lead the United Farm Workers Union.

In the late 1950s, Alinsky broadened his base of support from Chicago to Catholic dioceses and mainline Protestant denominations all over the county, to support

urban reform and fight racism. Alinsky (1972) emphasized several tenets of community organizing, namely:

- Organizations should encourage democratic decision making and indigenous leadership.
- Organizations should be open to all members of the community—the more diverse the organization, the stronger.
- Community organizing depends on gaining the support of traditional community leaders and existing organizations.
- Organizations must be geared to meeting people's self-interests, however they define those interests. Let the people decide, no matter what they decide.
- Based on the beliefs of the emancipationist Frederick Douglass, power concedes nothing without a fight. Organizations should use conflict strategies to yield the greatest gains.
- Organizations should fight for concrete victories, because winning builds organization.

Many other political activist organizations emerged in the 1960s out of the civil rights and student movements, such as Students for a Democratic Society and the Black Panthers. Although similar to the Alinsky model in stressing the need for democratic practices and confronting power with power, they emphasized fundamental social change, without great concern for building stable organizations. As a result, many did not last long; some dissolved on their own, and others were purposefully infiltrated and dismantled. Poor urban neighborhoods in the 1990s experienced persistent poverty and had fewer of the social institutions formed by Alinsky-style organizing that had helped them in the past. Most recent activist organizing occurs based on communities of identity—communities of color, gender, sexual orientation, ethnicity, or race (Fisher, 1994).

Neighborhood-Maintenance, or Community-Development, Approach

The *neighborhood-maintenance, or community-development, approach* aims to maintain or improve the physical and commercial value of the neighborhood or community, and not to accumulate power. First 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, and Torczyner, 1987). This approach is based on the assumptions that communities can develop the capacity to deal with their own problems; people should participate in making, adjusting, and controlling the major changes taking place in their communities; and changes in community systems that are self-imposed or self-developed have a meaning and permanence that imposed changes do not (Butterfoss and Kegler, 2002).

The neighborhood associations that emerged out of the suburban sprawl of the 1950s were essentially civic organizations developed by homeowners themselves to enforce deed restrictions in their neighborhoods. They functioned as improvement associations to supply services and lobby city hall for street repairs, park development, schools, and traffic signs. In some cases, they were used to prevent racial integration and panic selling. Most often, these types of organizations use peer pressure to maintain property. Sometimes they work with local officials or institutions to apply pressure to obtain services, and occasionally they take a more activist approach when they learn that they can achieve their goals only through confrontational or political means (Delgado, 1993).

However, the community development approach usually deemphasizes dissent and confrontation—these organizations see themselves as proactive consensus builders. The approach attempts to move toward community economic development and building community partnerships with local economic and political powers. In particular, nonprofit community development corporations that serve low-income communities, are governed by community-based boards, and develop businesses or housing developments have proliferated (Parachini and Covington, 2001).

In summary, Fisher and Romanofsky (1981) grouped community-organizing activities in the United States into four historical periods:

1890–1920. The bigness and disorganization of cities during this period of rapid industrialization and immigration was dealt with by organizing immigrant neighborhoods into "efficient, democratic, and, of course, enlightened units within the metropolis" (Fisher and Romanofsky, 1981, p. xii). Because reformers mostly built community through settlement houses and other service mechanisms, the dominant approach was social work.

1920–1940. Community organizing was established as a subdiscipline of social work. During the Great Depression, little was written about community organizing. Most organizations had a national orientation because the economic problems that the nation faced did not seem to be amenable to change at the neighborhood or community level.

1940–1960. Saul Alinsky's political activist approach fueled a new interest in community organizing from the social work perspective. Civil rights efforts and government involvement in reshaping cities and neighborhoods through postwar urban renewal programs aligned well with Alinsky's community movements. He promoted new awareness of community organizing among academics, who trained a generation of organizers like César Chávez.

1960–1980. Neighborhood organizing became widespread in the 1960s. In the early 1970s, activists and theorists such as Kurt Lewin informed organizations, movements, and strategies until the end of the century, in response to federal antipoverty programs and upheavals in cities. Lofquist's prevention model (1983) focused on strengths and assets of community members and associations. Building on an assets approach, civic associations and neighborhood block clubs were formed across the country to foster community spirit, civic duty, and social unity.

CONTEMPORARY EFFORTS AND MODELS OF SOCIAL ACTION COMMUNITY ORGANIZING

From the 1980s until today, community organizing has involved three basic approaches: campaigns, grassroots organizing, and coalition building. *Campaigns* are an effort to organize the community for a short-lived purpose, such as public awareness of a health or social issue, voter identification and turnout, or recruitment for public health screening and immunizations.

In *grassroots organizing*, community groups are built from scratch, and leadership is developed where none existed before—in other words, the unorganized are organized. The southern civil rights movement in the United States and national liberation struggles in the southern hemisphere serve as important models for community-based grassroots organizing oriented to self-determination and sharing the political liberties and material affluence of societies that have exploited people of color (Fisher, 2005). Fisher emphasizes that a key lesson learned from the struggles endured by people of color is that "if oppressed people—often illiterate, rural peasants with few resources—could mobilize, take risks, and make history, then people of other oppressed or threatened constituencies can, with sufficient organization and leadership, do the same" (p. 57).

Coalition building efforts seek to unite existing groups, such as churches, schools, and civic associations, to pursue a common agenda more effectively. Because coalitions often rely on existing leadership, they are sometimes derisively called *grass tips organizing* (Grohol, 2005). Powerful, multi-organizational groups and coalitions with track records have the potential to become significant long-term change agents. These groups have become increasingly sophisticated in "attracting allies, developing community cohesion, and marshalling power, not only locally but also on regional, state, and national levels" (Parachini and Covington, 2001, p. 9). This kind of organizing is based in geographic communities or communities of interest; is decentralized according to sectors and identity groups; has democratic processes and goals; and is funded most often by voluntary sources (Fisher, 2005).

Several models and typologies of community organization exist; for detail on the subject, readers are referred to Minkler's seminal text, *Community Organizing and Community Building for Health* (2005, pp. 26–133).The most well-known model is Rothman's (2001) typology of locality development, social planning, and social action.

Locality development is process-oriented and emphasizes consensus and cooperation aimed at building group identity and sense of community. *Social planning* is task-oriented and uses an outside consultant to help with problem solving. *Social action* combines the two models and focuses on increasing the community's skill at problem solving to achieve power and specific change (Rothman, 2001). Most organizers use a mixture of two or more of these models. For example, the Planned Action toward Community Health (PATCH) public health initiative mixed social planning and locality development models (Bracht, Kingsbury, and Rissel, 1999).

Some researchers and practitioners have recently found this typology to be limited because locality development discourages organizing that is not geographically based;

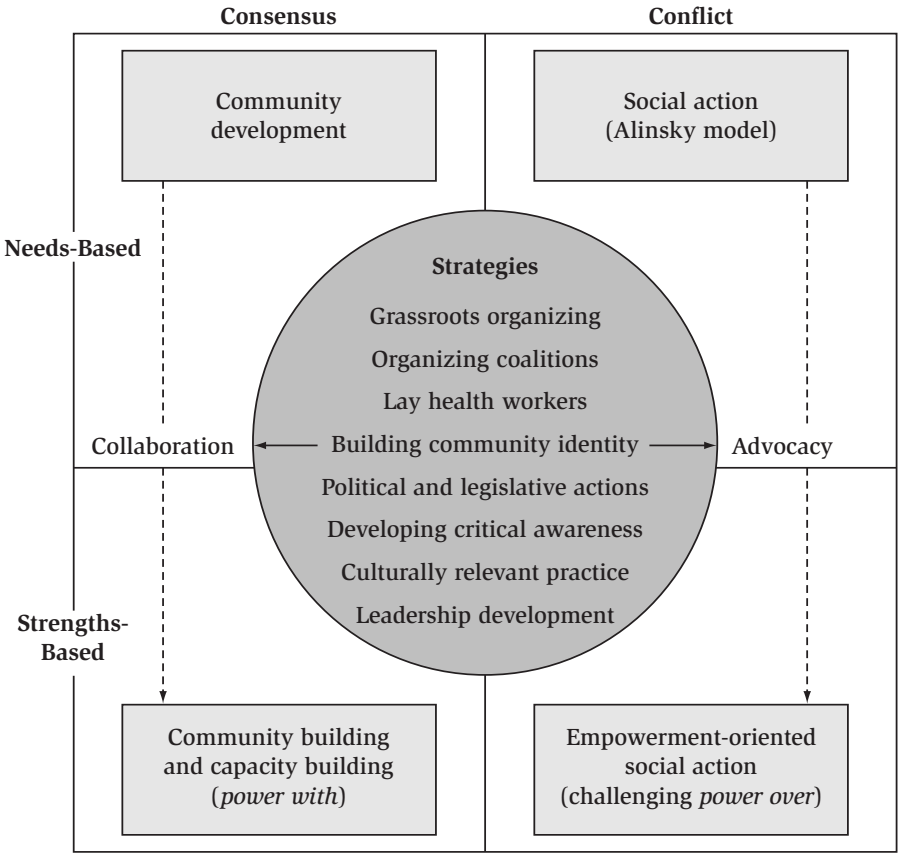

Figure 1.1 Community organization and community-building typology.

Source: Minkler & Wallerstein, 2005, p. 33. From *Community Organizing and Community Building for Health,* 2nd ed., edited by Meredith Minkler. Copyright © 2005 by Rutgers, the State University. Reprinted by permission of Rutgers University Press.

social planning relies on outside experts and not on building community capacity for planning and problem solving; and the model is problem-based, not strength-based, and organizer-centered rather than community-centered (Himmelman, 1992; Kaye and Wolff, 1995; LaBonte, 1994; Minkler and Wallerstein, 2003a).

Newer models of collaborative empowerment and community building have emerged over the past decade to complement the classic organizing approaches described earlier. These models are community-centered and emphasize community strengths, development of shared goals, and equitable power relationships.

Minkler's and Wallerstein's (2005) typology of community organization and community building, shown here in Figure 1.1, incorporates the classic need-based models (consensus-building *community development* and conflict-based *social action*) with the newer asset-based models (consensus-building *community and capacity building* and conflict-based, empowerment-based *social action*).

The strategies that communities use to solve their particular issues cross all of these approaches and run the gamut from grassroots organizing and coalition building, to leadership development, as shown in Figure 1.1. However, the consensus-based approaches (*community development* and *community building or capacity building*) tend to use collaborative strategies, whereas the conflict-based approaches (*social action* and *empowerment-oriented social action*) use more advocacy-type strategies. Notably, coalition building can be seen as both a model of community organizing and a strategy used across models. Coalitions can use need- or asset-based approaches at different times, depending on the social context of the community and the skills and readiness of community members to incorporate these approaches (Minkler and Wallerstein, 2005).

CONTEMPORARY ROOTS OF COALITIONS AND PARTNERSHIPS FOR HEALTH PROMOTION

In searching the community-organizing literature for the foundation of the modern coalition, one is struck by the lack of recent historic perspective on the subject. Because we are currently in the midst of writing the history on coalitions, perhaps we are waiting for the verdict as to whether these organizations are effective, sustainable, and durable before we consign them to the history books. This chapter has laid the groundwork for the coalition as a community-organizing model and as a strategy for resolving community issues and achieving community goals. Indeed, many of the community health coalitions that arose in the early 1990s drew their inspiration from the resurgence of community development and citizen participation movements of the late 1980s. Brief summaries about the key concepts of community development, citizen participation, individual and community empowerment, community capacity, community competence, and social capital follow.

Community Development

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, and Torczyner, 1987). This approach is based on several assumptions, namely that communities can develop 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. 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.

Citizen Participation

Several research studies in the early 1990s focused on *citizen participation*. The Neighborhood Participation Project examined the process of citizen participation

through a systematic study of block organizations in a Nashville neighborhood (Florin and Wandersman, 1990; Prestby and others, 1990; Prestby and Wandersman, 1985; Giamartino and Wandersman, 1983). *Community participation* is broadly defined as the process of involving people in the institutions or decisions that affect their lives (Checkoway, 1989). Closely related, *citizen participation* is the mobilization of citizens for the purpose of undertaking activities to improve the conditions in the community.

Community-participation researchers posed questions similar to those used 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 which are inactive? (Florin and Wandersman, 1990). Research questions asked in the Block Booster Project in New York City also helped shape the coalition research agenda (Perkins and others, 1990). The study suggested that aspects of a community's social and physical environment are more important indicators for participation in block associations than demographic attributes (years of residence, race, income, and home ownership) or crime-related problems, perceptions, or fears.

Perkins, Brown, and Taylor (1996) investigated resident survey data and observational ratings of the physical environment to determine the predictors of participation in neighborhoods in Baltimore, New York City, and Salt Lake City. In all three cities, informal neighboring and involvement in community organizations (for example, faith-based groups) consistently predicted participation, suggesting that people who are more involved in helping their neighbors are generally more involved in grassroots community issues.

Arnstein (1969) posited that citizen participation is a categorical term for *citizen power* (p. 216) and a method enabling citizens to bring about social reform that permits them to share in society's benefits. She offers a typology of citizen participation in the form of an eight-rung ladder. The bottom two rungs (manipulation and theory) are both regarded as "nonparticipation." At these levels, citizens are arranged on advisory committees or boards to educate them and get their support or to involve them in activities that are not likely to lead to change. Rungs three (informing), four (consultation), and five (placation) are presented as different "degrees of tokenism." Here, citizens have varying ability to express opinions and concerns, but no power to make decisions. The top three rungs (partnership, delegated power, and citizen control) are all regarded as degrees of "citizen power."

Empowerment

Empowerment is an often overused term that refers to a community's capacity to identify problems and solutions or to achieve equity (Cottrell, 1983; Rappaport, 1984). The accepted, broad public health definition of empowerment is the "process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environments to improve equity and the quality of life" (Minkler and Wallerstein, 2005, p. 34).

A resurgence of interest in community empowerment fueled the formation of community coalitions in the 1990s (Israel, Checkoway, Schultz, and Zimmerman, 1994;

LaBonte, 1994; Zimmerman and Rappaport, 1988). Zimmerman (2000) notes that empowerment can be used at the individual, organizational, or community level, and it is at the heart of citizen participation and control. Empowerment involves challenging power through community organizing and advocacy, and expanding power by strengthening community networks and organizations (Minkler and Wallerstein, 2005). Organizational empowerment speaks to coalitions because it involves both the process of change as well as its outcomes (for example, increasing community participation, achieving goals, attracting resources) (Zimmerman, 2000).

Nine factors that influence community empowerment are participation, leadership, problem assessment, organizational structures, resource mobilization, linkages to other individuals and organizations, inquisitiveness, program management, and the role of outside agents (Israel, Schultz, Parker, and Becker, 1998, pp. 180–181).

Unlike the block organizations referred to earlier, some coalition members may be characterized as "interested citizens" (or volunteers), although many represent organizations. Thus research and conceptual work done in the field of interorganizational relations is also relevant to coalition history. 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 and Wood, 1991; Berlin, Barnett, Mischke, and Ocasio, 2000; Provan and Milward, 1995).

Gray and Wood (1991) discuss several 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, and Yan, 1991; Mizruchi and Galaskiewicz, 1994). Institutional theory suggests that organizations adjust to institutional directives and norms in an attempt to achieve legitimacy (Gray and Wood, 1991; Gulati, 1995). Political science emphasizes the negotiation of potential conflict through coalitions and power distribution within coalitions (Bazzoli and others, 1997).

Community Capacity

Community coalitions have been recognized as a promising strategy for building capacity and competence among member organizations and, ultimately, in the communities they serve (Chavis, 2001; Kegler, Steckler, McLeroy, and Malek, 1998b). *Community capacity* is defined as the "characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems" (Goodman and others, 1998, p. 259). Dimensions of community capacity that coalitions can impact either positively or negatively include citizen participation and leadership, skills, resources, social and organizational networks, sense of community, understanding of community history, community power, community values, and critical reflection (Goodman and others, 1998).

Collaborative capacity refers to the conditions needed to promote effective collaboration and build sustainable community change (Goodman and others, 1998). Collaborative capacity is needed at four levels in the coalition: within members, within member relationships, within the organizational structure, and within the programs that coalitions sponsor (Foster-Fishman and others, 2001).

An emphasis on capacity is helpful, because a coalition's ability to promote change is dynamic (depending on the coalition's membership, focus, and stage of

development), adjustable (enhanced by technical assistance and training efforts), and transferable (the capacity developed within one coalition experience can carry over to other community-based efforts) (Foster-Fishman and others, 2001, p. 242). Crisp and colleagues (2000) identified partnership and coalition development as one of four distinct approaches to building capacity, arguing that two-way communication between groups not previously working together can result in more resources for planning and implementation.

Community Competence

The term *community competence* was developed by Cottrell (1983) to define how a well-functioning community behaves. Competence is similar to empowerment and is achieved when various parts of the community collaborate to identify its problems and needs, reach working consensus on goals and priorities, agree on ways and means to implement those goals, and collaborate effectively (Eng and Parker, 1994, p. 199).

The dimensions of community competence are commitment, participation, self-other awareness and clarity of situational differences, conflict containment and accommodation, management of relations within society, skills for facilitating participant interaction and decision making, articulateness, and communication (Eng and Parker, 1994). Community competence has been described as skillful application of community capacity (Goodman and others, 1998). Associated increases in community capacity and competence should contribute to future successful community problem-solving efforts (Goodman and others, 1998).

Social Capital

Finally, one last concept is integral to our discussion of community participation and organizational relations. *Social capital* is a term that describes the features that enhance coordination and cooperation within and among organizations, just as physical capital and human capital are tools that enhance individual productivity in society. In Robert Putnam's well-known work *Bowling Alone: America's Declining Social Capital*, he defines *social capital* as "the relationships and structures within a community, such as civic participation, networks, norms of reciprocity, and trust, that promote cooperation for mutual benefit" (Putnam, 1995, p. 66).

In essence, social capital is a bonding relationship between community members that results from their participation, trust, and reciprocity (Putnam, 1995; Minkler and Wallerstein, 2005). Putnam asserts that in the last thirty years, Americans have participated less in the political process and in organized religion. They have reduced their membership in unions and civic, fraternal, school service, and voluntary organizations. Finally, bowling in organized leagues decreased by 40 percent from 1980 to 1993, while the total number of bowlers increased by 10 percent during that same time (Putnam, 1995).

Even though Americans are more involved in tertiary and nonprofit organizations (that do not require face-to-face contact with other members or attendance at meetings), associational membership has declined by at least 25 percent during the last quarter century. This trend appears to be related to women moving into the work force, increased mobility of the population, demographic changes (for example, fewer marriages, more divorces, fewer children), and pursuit of more individual leisure

activities (for example, televisions, VCRs, video games) (Putnam, 1995). Restoring civic engagement and trust, then, is a key task that coalitions and partnerships must address if they are to survive.

The remainder of this chapter will chronicle the emergence and proliferation of community coalitions and partnerships as strategies not only to build communities but also to improve the health outcomes among their residents.

COALITIONS: A PUBLIC HEALTH STRATEGY TO BUILD CAPABLE, COMPETENT COMMUNITIES

The rise of coalitions as a prominent health promotion strategy parallels the growth of community-wide health promotion over the past three decades. This growth is partially due to the widespread dissemination of strategies employed in the National Heart, Lung, and Blood Institute's 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 community-wide cardiovascular disease prevention strategies (Shea and Basch, 1990; Carlaw, Mittelmark, Bracht, and Luepker, 1984; Mittelmark and others, 1986; Lefebvre, Lasater, Carleton, and Peterson, 1987; Farquahr, Fortmann, Flora, and others, 1990). Although these groups were not technically *coalitions,* they employed some of the same processes and strategies that coalitions currently use. 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 and 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 community-wide approaches recognize that behaviors are inextricably tied to the environment (Milio, 1989; Thompson and Kinney, 1990; Stokols, 1992; Tesh, 1988). No single approach for community change is as effective as a broad-based coalition effort that provides the means for multiple strategies and involves key community individuals (McLeroy and others, 1994). The general focus of community organizing for health promotion is on changing systems, rules, social norms, or laws, ultimately to change the social acceptability of certain behaviors. The venue for community organizing is often the policy arena and often involves 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.

Finally, how well community coalitions develop the *capacity* of communities to address future critical health issues is vital. 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, and Malek, 1998b).

THE RISE OF COALITIONS (1990–2006)

The proliferation of local, state, and national coalitions during the past sixteen years is remarkable. Health coalitions have been developed for health promotion, disease prevention, and access to care and treatment. Primarily, these coalitions are single-issue focused, although recently newer coalitions for reducing health disparities and chronic disease focus on multiple issues. Most of the coalitions are grass roots and community-based, but the logic of developing state and even federal counterparts takes advantage of the synergy created when collaboration across populations occurs. The international community is also involved in coalition building for cardiovascular disease, HIV/AIDS, immunization, and injury prevention, among other issues. The following summary of coalition development during this period is not all-inclusive but rather provides a snapshot of health coalition initiatives that are most visible and well funded.

Alcohol, Tobacco, and Other Drug Abuse Prevention

From 1990 until the present, coalitions continue to be used as an organizing strategy and process for change in public health. As the crack-cocaine outbreak of the late 1980s affected cities across America, citizens came together to form the kind of community coalitions familiar today (DrugStrategies, 2001). The first national meeting of community coalitions occurred in 1990, and the Community Anti-Drug Coalitions of America (CADCA) emerged as the voice for these grassroots coalitions (Birkby, 2003). The private sector and federal government rapidly became involved in contributing significant financial support and technical assistance for these groups. From 1990 to 2002, the Robert Wood Johnson Foundation (RWJF) contributed over $72 million to fund fifteen communities (between 100,000 to 250,000 residents) in eleven states to develop *community partnerships* in the Fighting Back initiative, which sought to prevent alcohol and other drug abuse among youth (Thompson, Spickard, and Dixon, 2001; Robert Wood Johnson Foundation, 2002).

The large number of communities that submitted proposals to the RWJF initiative spurred the Center for Substance Abuse Prevention to provide $375 million to fund 251 community partnerships in 1990–91 (Birkby, 2003). The John S. and James L. Knight Foundation funded eleven antidrug coalitions in their Community Initiatives program. Later, politicians adopted the Drug Free Communities Act and provided long-term support to reduce substance abuse in youth (DrugStrategies, 2001).

Evaluations of these health promotion coalitions have yielded a wide range of results. Some have been successful organizations, whereas others have disappeared; some have produced measurable changes in attitudes and community policies, whereas others appear to have had little effect (DrugStrategies, 2001).

During the same period, health advocates became concerned about the high rate of tobacco use. In 1988, the National Cancer Institute (NCI) launched the Community Intervention Trial for Smoking Cessation (COMMIT), a community-based smoking intervention trial in eleven pairs of matched communities. Then, in partnership with the American Cancer Society, NCI provided $128 million to fund the American Stop Smoking Intervention Study (ASSIST), the largest government-funded demonstration project to help states develop effective strategies to reduce smoking. From 1993 to 1999, ASSIST funded seventeen state health departments to use state and local coalitions to plan and implement programs to promote smoke-free environments, counter tobacco advertising and promotion, limit youths' tobacco access and availability, and increase tobacco prices by raising excise taxes. Study results showed that ASSIST states had a greater decrease in adult smoking prevalence than non-ASSIST states, and states that approved more tobacco control policies had larger decreases in per capita cigarette consumption (National Cancer Institute, 2003).

In 1993, the CDC launched its Imperatives to Prevent and Control Tobacco Use (IMPACT) program with cooperative agreements to the thirty-three states that did not receive ASSIST funding. In 1997, the federal government spent about $46 million for tobacco control efforts (The Advocacy Institute, 1998). At the state level, tobacco excise tax increases, dedicated in part to tobacco control, created large antitobacco efforts in some states. For example, California spent over $132 million in 1996 on tobacco control programs that included educational programs, cessation efforts, support for community coalitions, and a statewide media campaign.

Private efforts, such as the SmokeLess States initiative funded by the Robert Wood Johnson Foundation in 1994, provided additional resources to state-level coalitions working to reduce tobacco use. Over time, RWJF spent $110 million to expand the SmokeLess States program to fund at least some activities in thirty-one states and two cities; nine states were also funded by the SmokeLess States National Program Office (NPO) to assist in developing plans for comprehensive tobacco programs. Finally, individual state settlements with tobacco companies and the 1998 Master Settlement Agreement (MSA) between tobacco companies and the remaining states provided new revenues to states (Robert Wood Johnson Foundation, 2005b). Some states have committed some or a significant share of these funds to comprehensive tobacco control programs (U.S. Department of Health and Human Services [USDHHS], 2000).

Although greater funding has reduced tobacco use, little is known about the relative impact of subcomponents of these tobacco control programs, such as state and community coalition interventions (Farrelly, Pechacek, and Chaloupka, 2001). SmokeLess States focused most on reducing tobacco use by strengthening tobacco control legislation and regulation with major impact. For example, thirteen of the sixteen states that raised tobacco excise taxes since 1994 were SmokeLess States. Similarly, a disproportionate number of new local clean indoor air ordinances were adopted in SmokeLess States. Moreover, of the thirty-nine states that committed settlement funds to tobacco control programs, thirty are SmokeLess States, with average funding levels nearly five times those of the other nine states (ImpactTeen, 2005).

Immunization Promotion

Likewise, in response to the 1989–1991 measles epidemic that resulted in 55,000 reported cases and 123 deaths, the former first ladies of the United States and Arkansas, Rosalynn Carter and Betty Bumpers, founded Every Child by Two (ECBT) in 1991. To promote timely immunization of all American children by age two, ECBT supports statewide immunization efforts in developing public and private partnerships, collaborative activities with managed care organizations, school-based sites for preschool immunizations, education of health care providers, immunization registries, and global eradication of polio and measles (Every Child by Two, 2005). In 1993, President Clinton was prompted to support the Childhood Immunization Initiative, which established coalition development in all states, twenty-nine large urban areas, and seven territories as one of its major goals (Centers for Disease Control and Prevention, 1993). The Horizons project was funded by the Health Care Financing Administration (HCFA) as a collaborative venture between professional review organizations and nine historically black colleges and universities in eight southern states. Its goal was to increase vaccine coverage rates among older black populations by providing vaccines in nontraditional community settings, such as shopping malls, senior citizen centers, voting sites, and parks (Centers for Disease Control and Prevention, 2000c).

Many of these coalitions, still active in their communities, promote similar goals to ECBT and advocate for policy change at the state level. National-level partnerships to improve immunization rates across the age span include the Hepatitis B Coalition, the Immunization Action Coalition, and the National Partnership for Immunization. These groups bring together health care professionals, state coalitions, advocacy groups, and vaccine companies to promote immunization awareness, education, and access to and delivery of vaccines to the general public.

Oral Health Promotion

Wide-scale building of oral health coalitions in the United States is relatively recent. These coalitions have developed in response to the lack of fluoridated water in nearly 30 percent of medium to large metropolitan areas; the high rates of caries among children and adults of low income; and the need to create statewide plans to improve oral health knowledge, prevention of oral cancers, and dental sealants for children. In 2003, the Surgeon General issued the first Oral Health Call to Action, which brought these issues to national attention (U.S. Department of Health and Human Services, 2003).

After two years of discussion, the National Oral Health Partnership was launched in 2005, with funding from major partners such as Oral Health America, the American Dental Association, the American Dental Hygienists Association, and Delta Dental (insurer). The Oral Health Division of the CDC funds active oral health programs in fifteen states to promote state planning, sealant programs, and the development of state oral health coalitions. Illinois, California, and Kentucky have the largest coalitions, with Kentucky's being the oldest (established in 1989) (Oral Health America, 2001). Currently, coalitions exist in eighteen states, with funding from insurers, dental product and other business corporations, grants, and the CDC. Thirteen states also have health care coalitions that address oral health issues.

Teen Pregnancy Prevention

Most reviews of the adolescent pregnancy prevention literature find serious program shortcomings and conclude that broad-based, community-wide, comprehensive interventions focused on prevention are the best approach (Brindis, 1991; Carnegie Corporation, 1989; Dryfoos, 1990; Moore and others, 1995; Santelli and Beilenson, 1992). Community partnerships have often been promoted to coordinate these community efforts (Edwards and Stern, 1998). The National Strategy to Prevent Teen Pregnancy was initiated by USDHHS in 1997 in response to a call from Congress for a strategy to reduce teen pregnancies and to assure that at least 25 percent of U.S. communities have teen pregnancy prevention programs in place (Edwards and Stern, 1998). Since then, multiple efforts have continued to mobilize communities to prevent adolescent pregnancy: The CDC provides $6.5 million to thirteen community partnerships in eleven states to develop comprehensive programs; the California Wellness Foundation provided $60 million to California partnerships; the Annie E. Casey Foundation committed $5 million to five communities; and the Colorado Trust in Colorado and the Flinn Foundation in Arizona provided millions of dollars of support for similar efforts (Gallagher and Drisko, 2000).

Injury Prevention

Safe Kids USA was founded in 1987 by Children's National Medical Center, with support from the Johnson & Johnson Corporation to prevent accidental injury, a leading killer of children aged fourteen and under. In 2005, the nearly twenty-year-old National Safe Kids USA joined with the international Safe Kids movement to become Safe Kids Worldwide (Safe Kids, 2005). More than 450 coalitions in all fifty states and sixteen countries bring together safety and health experts, educators, corporations, governments, foundations, and volunteers to educate and protect families. Creating national awareness and promoting sound research, child safety laws and regulations, and lifesaving devices (for example, child safety seats, helmets, smoke alarms) are goals that are accomplished by empowering local communities to build grassroots coalitions.

HIV/AIDS Prevention

The Ryan White Care Act mainly covered access to treatment and nondiscriminatory provision of services for HIV/AIDS. However, from 1993 to 1998, the CDC directed states and localities receiving HIV prevention funds to conduct community planning efforts that involved communities and especially persons living with HIV and AIDS. Many of these communities also established coalitions that included persons living with either HIV or AIDS or both to ensure that their concerns were heard. In 2002, USDHHS's Health Resource and Services Administration (HRSA) funded $10 million to plan and expand community-based HIV/AIDS care. This funding covers fifty-eight one-year planning grants, twenty-nine capacity-building grants to develop or enhance care, and twelve community-based dental partnership grants.

Although these grants are not directed only to coalition building, many communities have formed durable partnerships around this critical prevention issue (HRSA, 2002). The Minority Community Health Coalition Demonstration Program was

developed in 1999 as part of the Minority HIV/AIDS Initiative to address the epidemic in minority communities. The program is intended to demonstrate the effectiveness of community coalitions involving nontraditional partners to develop an integrated response to the HIV/AIDS crisis through community dialogue and interaction; to address sociocultural, linguistic, and other barriers to HIV/AIDS treatment in order to increase the number of people who seek and accept services; and to develop and conduct HIV/AIDS education and outreach for hardly reached populations. Currently funded by the Office of Minority Health (OMH) of the USDHHS, the seventeen grants are administered by community-based, minority-serving organizations that work in a coalition setting with at least two other partners. Notable national partnerships include AIDS Action; AIDS Alliance for Children, Youth and Families; AIDS Treatment Activists Coalition; AIDS Vaccine Advocacy Coalition; Communities Advocating Emergency AIDS Relief Coalition (CAEAR); and the Community HIV/AIDS Mobilization Project Office of Minority Health, 2003.

In Africa, the growth of coalitions and networks for HIV/AIDS advocacy has accelerated in the past ten years, following various United Nations global conferences and conventions. Coalitions that operate at national, regional, and subregional levels include Society of Women Against AIDS in Africa (SWAA), with chapters in many African countries; the AIDS NGO Network of East Africa (ANNEA); and Persons Living with HIV/AIDS (PLWHA). Although many of these coalitions exist, the presence or absence of funding to support one or two key individuals determines whether the local coalition is an active, effective tool for advocacy (Opubor, Egero, and Mensah-Kumah, 2000).

Promoting Health Insurance

In 1997, Congress designated funds for the State Children's Health Insurance Program (SCHIP) or Medicaid to provide health care coverage to children in working families with modest incomes. Although since 1972 the Robert Wood Johnson Foundation has sought to expand health insurance coverage as part of its mission to improve health and health care for all Americans, the foundation helped make both the new SCHIP and Medicaid programs easier for families to use and understand through their Covering Kids and Families (CKF) initiative, begun in 2001.

The cornerstones of the CKF initiative are the statewide and local coalitions in every state that work with public officials, health professionals, businesses, social service agencies, and faith-based and other organizations. The goals of these coalitions are to simplify enrollment and renewal processes for Medicaid and SCHIP programs to make them more family-friendly; make administrative procedures more efficient; and conduct outreach programs to identify, enroll, and retain eligible children. Programs for adults and pregnant women were recently added (Robert Wood Johnson Foundation, 2005a).

Prevention of Chronic Disease: Cardiovascular Disease, Cancer, and Diabetes

Despite the fact that cardiovascular disease is the leading cause of death in every state, the CDC currently funds only eight programs (through state health departments) to help prevent and control heart disease, stroke, and other cardiovascular

disease. States often partner with the American Heart Association and other site agencies to supplement funding for this important issue. CDC's Comprehensive Cancer Control program has existed since 1998 and funds forty-nine states (excluding Idaho), five tribal health agencies, and six territories to establish broad-based coalitions, assess the burden of cancer, develop plans and priorities for prevention and control, and implement these plans. The American Cancer Society and numerous foundations are major partners in these efforts. The National Alliance of State Prostate Cancer Coalitions (NASPCC) formed in 2005 to represent state coalitions made up of cancer survivors and community and family members. NASPCC aims to raise the national awareness and priority of prostate cancer throughout the United States.

CDC's Diabetes and Control Program funds states in a manner similar to those programs for cardiovascular disease and cancer. Coalition building is recommended at state and community levels. Under CDC's National Program to Promote Diabetes Education Strategies in Minority Communities, eight national organizations were funded to build coalitions to improve education and access to diabetes treatment. Funded organizations include the Black Women's Health Imperative, National Alliance for Hispanic Health, National Medical Association, Papa Ola Lokani (Asian Pacific Islander group), and Khmer Health Advocates (Cambodian).

Asthma

The alarm for asthma officially sounded in 1998, when the CDC reported that childhood asthma had reached epidemic proportions, with the number of cases increasing 160 percent for children under five and 74 percent for children five to fourteen years old from 1980 to 1994 (Mannino and others, 1998). Because asthma does not have a single etiology, the focus of effective management is control and prevention. Inner-city communities have responded to this challenge by forming broad-based coalitions that mobilize local resources to create friendly environments for children with asthma in home, school, and play settings. Asthma coalitions focus on identifying patients with asthma or those at risk for developing asthma, and include an educational component that promotes asthma awareness and self-management.

In 2001, the Robert Wood Johnson Foundation authorized $12.5 million to fund eight community-based coalitions for four years to implement comprehensive asthma management programs that include improved access to and quality of medical services, education, family and community support, and environmental and policy initiatives (Clark, Malveaux, and Friedman, 2006). CDC also funded thirty asthma partnership projects in 2001 under its National Asthma Control Program. In 2002, CDC funded Controlling Asthma in America's Cities, a five-year coalition-based project in eight U.S. cities that built on the experiences of the Allies Against Asthma project (University of Michigan, 2004). In 2002, the California Endowment launched its three-year initiative, Community Action to Fight Asthma (CAFA) that funded fifteen new asthma coalitions and linked them with thirteen other funded coalitions through four Regional Centers and a State Coordinating Office. The focus of CAFA is on reducing the prevalence of and exposure to indoor and outdoor environmental triggers for California's school-aged children. The established coalitions' focus on improving access to care and treatment for asthma was transformed to broader, collaborative goals of policy advocacy, media, and evaluation. Results from

these combined asthma coalition initiatives, funded by national and private sources in over forty cities, are forthcoming.

Multiple Health Issue Coalitions: Turning Point Initiative

In 1997, the Robert Wood Johnson and W. K. Kellogg Foundations developed a program called Turning Point. Among other issues, the program issued a request for proposals that encouraged local and state applicants to rethink the delivery of public health, placing emphasis on state and local collaborative partnerships and eliciting ideas on intervention priorities from community partners. Individuals and organizations from different sectors in many communities and states came together to transform their public health systems to achieve the goals of preventing disease and injury, protecting the public from threats to health, and promoting healthy behaviors (Turning Point, 2005). The state grantees developed specific models for more effective and responsive public health systems. Through twenty-one state partnerships of state and local public health and community-based agencies and five national collaboratives, Turning Point (2005) accomplished the following objectives:

- Improved the accountability of public health efforts
- Developed a model law to update public health statutes
- Increased the effectiveness of public health information technology
- Motivated changes in behaviors to promote good health outcomes
- Promoted skills and competencies of public health practitioners and leaders

At the national level, Turning Point collaborated with other public health organizations to realize its goals. Specifically, state partnerships were focused on identifying the most important health needs of residents in their communities; creating effective and accountable structures to deliver public health services to their communities; developing population data that support decision making about public health priorities; generating strategies to improve the health status of individuals, families, and communities; targeting the best ways to eliminate health disparities among and within populations; and providing evidence of the effectiveness of their partnerships (Turning Point, 2005). These crosscutting partnerships developed many measurable outcomes that will be described in later chapters. The national office produced many effective training materials and modules on collaborative leadership, social marketing, performance management, and public health statutes that can be found online at http://www.turningpointprogram.org/.

Racial and Ethnic Approaches to Community Health (REACH) 2010

Launched in 1999, Racial and Ethnic Approaches to Community Health (REACH) 2010 is one of CDC's main efforts to eliminate racial and ethnic disparities in health, with appropriations of about $34 million per year to support forty projects, four of which serve the elderly. Other major funders and partners of this effort include the National Center on Minority Health and Health Disparities (NCMHHD) at the National Institutes

of Health (NIH), Health Resources and Services Administration (HRSA), and the Administration on Aging.

REACH 2010 is designed to eliminate disparities among African Americans, Native Americans, Alaska Natives, Asian Americans, Hispanics, and Pacific Islanders in six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV/AIDS, and infant mortality. REACH 2010 supports community coalitions to design, implement, and evaluate community-driven strategies to eliminate health disparities. Each coalition must have at least one community-based organization and three other organizations, one of which must be a local or state health department, or an academic or research organization. Coalition activities include continuing education for health care providers, health communication campaigns and health education, and promotion programs that utilize lay health workers to reach community members (Centers for Disease Control and Prevention, 2005).

Steps to a HealthierUS

Steps to a HealthierUS is a five-year cooperative agreement initiative from the U.S. Department of Health and Human Services that advances the goal of helping Americans live longer, better, and healthier lives. States, cities, and tribal entities receive funds to implement chronic disease prevention efforts that focus on reducing the burden of diabetes, overweight, obesity, and asthma, and address three risk factors—physical activity, poor nutrition, and tobacco use.

In 2003 and 2004, the Steps program allocated nearly $50 million to fund forty sites that represented seventeen large cities, three tribes, seven states, and twenty-five small cities and rural communities. Under the guidance of a coalition, each site must implement in school, health care, and workplace settings a community action plan that focuses on community interventions (for example, walking programs, media campaigns); environmental interventions (for example, smoking cessation, healthy food choices in schools); and educational interventions (for example, coordinated school health programs) (Centers for Disease Control and Prevention, 2004).

SUMMARY

The collaborative work involved in building coalitions to promote health and prevent disease has its roots firmly entrenched in the early history of America. From Benjamin Franklin's work in building associations to improve civic life and Alexis de Toqueville's observations of *Democracy in America,* succeeding generations of Americans continued to organize for social, economic, and political justice. *Community organizing* is a process by which ordinary people—most often with low to moderate incomes—are brought together to act in their common self-interest, while seeking the ideals of participatory democracy.

The community-organizing movements of the 1800s focused on improving Americans' health and quality of life through the work of feminists and abolitionists. In the twentieth century, three dominant types of community organizing emerged: social work approaches that resulted in settlement houses and trade

unions; political activist approaches espoused by Saul Alinsky, such as those used in civil rights and student movements; and neighborhood maintenance–community development approaches to build and empower neighborhoods, used in postwar and antipoverty programs spearheaded by Kurt Lewin.

Community participation is broadly defined as the process of involving people in the institutions or decisions that affect their lives, and *citizen participation* is the mobilization of citizens for the purpose of undertaking activities to improve the conditions in the community. These activities defined the development of neighborhood block associations in the 1970s and 1980s, the precursors to modern coalitions. Finally, research in interorganizational relations focused on the formation of collaborative relationships in an effort to understand why organizations join collaborative alliances.

Modern coalitions for health promotion and disease prevention emerged in the late 1980s and early 1990s and continue to proliferate today. Multiyear funding for local, regional, state, and national coalitions is often substantial, and the expectations of success are high. Coalitions have been formed for single issues such as the promotion of immunizations and oral health; the prevention of alcohol, tobacco, and other drug abuse; teen pregnancy; and HIV/AIDS. Chronic disease prevention for cancer, cardiovascular disease, diabetes, and asthma are more recent issues around which coalitions mobilize. Finally, multi-issue coalitions for chronic disease prevention and for the elimination of racial and ethnic health disparities are the latest health improvement investments by federal and private funders.

QUESTIONS FOR REVIEW

1. What are the similarities and differences between coalitions and associations?
2. How do the community organizing approaches used by modern health coalitions differ from those used by coalitions developed to establish trade unions or promote civil rights?
3. Explain how each of these terms relates to the work of coalitions for health promotion and disease prevention: citizen and community participation, community empowerment, and social capital.