Achieving organizational change: findings from case studies of 20 California healthy cities and communities coalitions

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Abstract:

SUMMARY

As part of an evaluation of the California Healthy Cities and Communities (CHCC) Program, we assessed the extent to which coalitions implementing the healthy cities and communities model demonstrated capacity to leverage financial resources, expand programs and influence organizational policies. The evaluation design was a multiple case study of 20 participating communities with cross-case analysis. Participating communities spanned the state's diverse geographic regions and ranged from remote areas within rural counties to neighborhoods within large cities. Data included: semi-structured interviews with coordinators and community leaders, focus groups with coalition members and document review. Many CHCC coalitions were able to leverage significant financial resources across a diverse array of funding sources, including federal, state, county, and city governments. In addition, all CHCC coalitions developed at least one new program, most commonly focused on youth development, civic capacity-building or lifelong learning. Changes in policies, reported by 19 of the 20 coalitions, were consistent with healthy cities and communities principles and were implemented in community-based organizations, county and city governments, and school districts. Typical changes included an increased willingness to collaborate, increased emphasis on engaging diverse parts of the community, greater responsiveness to community needs and more opportunities for resident input into decision-making. Our findings suggest the healthy cities and communities model has the potential to strengthen the organizational infrastructure of communities to promote health.

Keywords: coalitions; community capacity; healthy cities; organizational change

Article:

INTRODUCTION

The Healthy Cities movement emphasizes a broad definition of health, multi-sectoral partnerships, the development of community capacity and systems change (Hancock and Duhl, 1986; Hancock, 1988; Norris and Pittman, 2000). The original Healthy Cities model focused on municipal governments, based on the premise that city governments had responsibility for many of the functions that influence major determinants of health (Hancock and Duhl, 1986; Flynn, 1996; Twiss, 1997). In 1998, the California Healthy Cities Project expanded its efforts beyond city governments to engage more diverse types of lead agencies, such as community-based organizations and county governments (Twiss *et al.*, 2000). To capture a broad range of possible outcomes from this initiative, a multiple case study was conducted using a framework that organized potential outcomes, identified by Healthy Cities coordinators, into five levels of the social ecology: individual, civic participation, organizational, inter-organizational and community (Kegler *et al.*, 2000). The current paper reports findings from the organizational level of this framework and helps to illuminate the ways in which the healthy cities and communities model can alter a community's organizational infrastructure to promote community health.

Much of community health improvement occurs through organizations; organizations develop programs, obtain and allocate resources and implement policies that directly affect the quality of life for community residents. Additionally, organizations provide goods and services, create and reinforce community identity, leverage and

broker external resources and serve as the mediating structures through which people interact with their communities (McLeroy *et al.*, 1988; Crisp *et al.*, 2000; Chaskin *et al.*, 2001). From a systems perspective, organizational change can also be a catalyst for broader-scale community change; in other words, a change in organizations and their interrelationships can impact the system as a whole (Thompson and Kinne, 1999).

Relatively few published evaluations of healthy cities and communities initiatives, or similar coalition-based approaches to health promotion, have attempted to assess organizational change (Flynn et al., 1992; Flynn, 1996; Lee et al., 2000; Kurland, 2000; Wallerstein, 2000; Connor, 2005). Methods do exist, however, for measuring organizational change. The monitoring and feedback system developed by Fawcett and colleagues documents community or systems changes, operationalized as new or modified programs, policies or practices, as initial markers of progress in the pathway to more distal health outcomes (Francisco et al., 1993; Fawcett et al., 1997; Paine-Andrews et al., 2002). Others have used surveys of organizations to assess improvements in health promotion delivery systems or network analysis to assess inter-organizational collaboration (Weisbrod *et al.*, 1992; Provan *et al.*, 2004). Florin et al. (Florin *et al.*, 2000) used key informant ratings of the effect of coalitions on organizational policies and practices within a community, and Hays et al. (Hays *et al.*, 2000) used coalition member assessment of coalition impact on local public policies related to substance use.

In our previous work, we reported on skills gained by coalition members (Kegler *et al.*, 2006), the development of new leadership roles in communities (Kegler *et al.*, in press) and the development of a broader perspective among coalition members on the importance of various determinants of health (Aronson *et al.*, 2007). In this paper, we present organizational results from case studies of the 20 communities that participated in the California Healthy Cities and Communities (CHCC) Program from 1998 to 2003.

METHODS

Description of the CHCC program

Twenty communities were selected competitively and funded for 3 years, with each receiving $25 000 in the planning year, and $50 000 in each of two implementation years (Twiss et al., 2000). Selected communities spanned the state's diverse geographic regions and ranged from remote areas within rural counties to small municipalities to neighborhoods within large cities. Populations varied from 1200 to 130 000 residents, with population densities ranging from 1.0 to 12141 persons per square mile. Urban sites were more ethnically diverse than rural sites, although 12 of the communities, both rural and urban, had relatively large Hispanic populations (>20%). In the first year of funding, grantees were required to solidify a governance structure or coalition that was broad-based and multi-sectoral. Each coalition created a vision for the future, conducted an asset-based community assessment, selected a priority issue and developed a plan specifying actions aimed at community health improvement. The subsequent 2 years were spent implementing and evaluating the action plan, and planning for sustainability.

Data collection instruments and measures

Data reported here are from progress reports and final interviews with coordinators and other local staff (n = 28) collected in all 20 communities, supplemented with data from focus groups (n = 9 groups) and interviews with community leaders (n = 16) in nine communities where site visits took place. Communities selected for site visits represented variation in location (Northern California, Central Valley, Southern California), sponsorship (e.g. city government, community-based organization) and population density. The evaluation protocol was approved by the Emory University Institutional Review Board.

Leveraged financial resources

Initial data on leveraged resources were obtained from progress reports. Through interviews, coordinators verified and updated a list of financial sources and amounts. Coordinators were asked to include only resources resulting from the influence of the CHCC coalition. In communities where site visits were conducted, community leaders involved with the local project were also asked to identify significant financial resources.

New or enhanced programs
The progress reports also provided initial data for a matrix that listed new or enhanced programs with continued commitments of support. As part of the final interview, coordinators were asked to confirm the accuracy of the information and, for each program, to provide a statement of its purpose, the lead organization and a brief description of how their CHCC coalition influenced its development.

Three members of the evaluation team used the program matrices to independently sort the sites into three levels of program expansion: substantive, moderate or limited. These categories were based on total number of new programs and extent of program development beyond the scope of the local CHCC action plan. In addition, those classified as substantive or moderate also demonstrated evidence of improved infrastructure for program development in the broader community. Discrepancies in groupings were resolved through consensus.

Changes in organizational policies and practices
Data from progress reports also provided a starting point for a more thorough review of policy change. In the final interviews, coordinators and community leaders were asked to identify governmental and non-governmental policies that their CHCC coalition was able to influence. The resulting information was compiled into matrices that were then used by the evaluation team to classify sites into three categories based on the extensiveness of organizational policy and practice change: substantive, moderate or limited. Three members of the evaluation team independently sorted the communities based on factors such as the amount and significance of organizational change, variety of organizations affected and extent to which the changes reflected a shift in power roles to benefit community interests. Discrepancies were resolved through consensus.

Facilitating and inhibiting factors
To assess factors that influence organizational change, coordinators were asked to reflect on the factors that facilitated and/or inhibited organizational-level change.

Data analysis
Interviews were tape-recorded and transcribed verbatim. Each interview transcript was independently coded by two members of the evaluation team, with discrepancies in coding resolved through discussion (Strauss and Corbin, 1990). Text retrievals were completed using the qualitative data analysis software package QSR N6, followed by content analysis (Richards, 2002; Patton, 2002; Miles and Huberman, 1994). For most of the analyses reported here, the detailed matrices served as the primary data source.

RESULTS

Leveraged financial resources
Nine sites were able to obtain financial resources from over six distinct funding categories (e.g. federal government); only four sites had funding from two or fewer funding categories. As seen in Table 1, seven of the sites obtained federal funding; 13 obtained state funding; and 12 were able to secure funds from county governments. The most significant federal funding came from the U.S. Departments of Justice and Education. State funding often came from state tobacco tax dollars devoted to early childhood development (California Prop 10) and the California Department of Education. County funds typically took the form of grants or contracts under the purview of departments of social services and public health. When CHCC coalitions were successful in tapping municipal budgets, the funds were either line itemized for enhanced city services, community grants and contracts or else were appropriated from general funds for a one-time purpose.

One urban coalition accounted for a large proportion of the leveraged funds, with commitments exceeding $9 million in grants and contracts. Table 1 presents the distribution of sites leveraging different levels of dollars. Seven sites leveraged over $1 million and eight sites leveraged between $100 000 and $1000 000. Government funds accounted for 80% of the total dollars leveraged. Across all 20 sites, an estimated $21 million in financial resources was reported in new money leveraged by the coalitions for community health improvement— an 8.4-fold return on the original CHCC grant investment. The mean dollars leveraged per capita in the seven most rural sites (population density <100 persons per square mile) was much higher at $95 per person compared to

the six most urbanized sites (population density >5000 persons per square mile) which leveraged a mean of $35 per person.

Table 1: Description of funds leveraged due to CHCC coalition influence

Characteristics of resources leveraged	Number of coalitions ($n = 20$)	Percent of coalitions
Funding sources		
Federal	7	35
State	13	65
County	12	60
City	7	35
School district	3	15
Special district	4	20
Health philanthropy	7	35
Other philanthropy	11	55
Tobacco settlement	2	10
Private sector	13	65
Fundraising	9	45
Total resources leveraged in dollars[a]		
<100 000	5	25
100 000–499 999	6	30
500 000–999 999	2	10
1000 000+	7	35

[a]These figures are based upon all financial resources leveraged during each site's three-year grant period and confirmed grant commitments secured during that period, even if a portion of the grant' disbursements was scheduled to occur following the end date of the CHCC grant.

New and expanded programs

All of the 20 participating communities developed or expanded at least one program, with the vast majority developing or enhancing more than one program scheduled to continue beyond the CHCC funding period. These programs generally fell into one of the eight areas listed in Table 2. Eighteen of the sites developed programs to promote the healthy development of children and youth and 14 sites designed programs to strengthen civic capacity. In addition, 12 sites developed programs classified as lifelong learning, and half of the communities developed new programs to promote volunteerism.

Five coalitions demonstrated substantive achievement by developing or expanding a comparatively large number of new programs (.10) in combination with enhancing program development capacity through establishment of a new community-based organization or realignment of responsibilities within existing organizations. These sites were distinctive in several ways. For example, new programs were sometimes developed and operated by community agencies other than by the grantee or coalition, indicating the presence of strong partnerships. Moreover, most of these programs addressed priorities identified in the CHCC planning process but went beyond the scope of the 2-year action plan implemented by the coalition. To illustrate, the action plan of one high-achieving rural site used a non-profit cafe´ to serve as the platform for after school and summer youth activities, a teen leadership group, GED (high school diploma equivalent) preparation for adults and public internet access. Community partners in this same site created a farmers market and a community library in an abandoned building.

Four sites were classified in the moderate expansion category with a notable impact on the availability of prevention programs in the community and a modest strengthening of program development capacity. In comparison to those classified substantive, these coalitions influenced the development of a smaller but still sizeable number of on-going programs (typically 5–10).

Table 2: Description of newly developed and expanded programs due to CHCC coalition influence ($n = 20$)

Program development focus	Number and percent of sites with ≥1 program, *N* (%)	Examples of programs developed or expanded
Youth and child development	18 (90)	Supervised alternative activities Community-based academic tutoring
Civic capacity-building	14 (70)	Leadership and non-profit skill-building Adult civic education programs
Lifelong learning	12 (60)	Adult literacy, GED and ESL classes Adult enrichment clubs/classes
Volunteerism	10 (50)	Time exchange (barter) programs Community service activities
Neighborhood improvement	7 (35)	Community gardens Graffiti, recycling and clean-up activities
Economic development	6 (30)	Small business plans and start-ups Business resource library
Recreation	5 (25)	Fine and performing arts programs Outdoor exploration
Inter-group relations	3 (15)	Community dialogues on race Diversity training
Other service-related activities	11 (55)	Transportation services Health screening and rural health care

Eleven sites were characterized by limited program expansion. These sites implemented fewer programs (typically less than 5), engaged fewer community partners in program expansion and tended to limit their programmatic influence to their own action plans.

Organizational policies and practices

Nineteen of the 20 coalitions reported positive organizational policy or practice changes (referred to as policy changes hereafter). Table 3 provides examples of changes in organizational policies by type of organization. Fifteen coalitions reported at least one policy change in a non-profit organization. Typical changes included: an increased willingness to collaborate, an increased emphasis on engaging diverse parts of the community and increased responsiveness to community needs. In addition, community-based organizations embraced an assets orientation, placed youth and residents on advisory boards, and broadened their missions. Fourteen coalitions reported success in changing a school or school district's policies. Common changes in schools included making facilities available for use by community groups and structured collaboration between community organizations and school districts in providing enrichment and tutoring programs.

Eleven sites reported success in changing at least one county government policy. These changes included a re-shifting of budget priorities to provide services to a previously underserved section of a county or community and structured collaboration with groups that represented underserved areas or populations. Multiple units of county government were influenced including a county library system, a neighborhood services department, public health and social services departments and a sheriff's office. Lastly, ten sites reached out and successfully engaged city policymakers causing police, code enforcement officers, recreation staff, transit workers, planners and even city council members to modify the way they did business through changes in internal practices and public policies. Changes included increased responsiveness to community needs, appointment of residents and youth to advisory groups, and institutionalized systems and practices reflecting sensitivity to immigrant populations.

Three coalitions were classified as achieving substantive change in organizational policies and practices. These sites reported comparatively large numbers of changes across a wide range of organizations. One of these sites, for example, influenced the city council to: purchase property as a neighborhood safe haven, create a citizen's task force on youth, and to sponsor a civic education program. City parks and recreation translated program materials and city police changed interrogation protocols to recognize cultural and language distinctions within the community. In addition, the county library began offering a story-time in Spanish; the school district hired its first trilingual teacher; a local college began to offer activities and support to a low-income minority

neighborhood; and a museum hired a bi-lingual docent. The county, city and local United Way also simplified the grant-writing process for community groups by adopting a standardized application and a unified grants review system.

Table 3: Description of organizational policies and practices influenced by CHCC coalitions ($n = 20$)

Type of Organization	Number and percent of sites with ≥1 policy or practice change, *N* (%)	Examples of policies and practices
Private non-profit organizations	15 (75)	A child abuse prevention council adopted a youth assets framework for all grant-seeking efforts A community foundation created a youth committee to provide advice on youth grant making
County governments	11 (55)	A county board of supervisors established a county parks and recreation agency A sheriff's office allocated staff and budget to initiate a Neighborhood Watch training to community groups
School districts	14 (70)	A school district initiated after-school bus transportation A school district agreed to open a gymnasium after-hours for community use
City government	10 (50)	A planning commission committed to include two youth members on its citizen advisory board A city government purchased a building for a teen center and offered a 15-year, no interest lease/ purchase option

Ten coalitions achieved moderate levels of change in organizational policies, and seven achieved limited change. These latter coalitions tended to report smaller numbers of changes, albeit still important changes, which were often linked to implementation of their CHCC action plan.

Organizational change across categories of funding, programming and policies

One community achieved substantive change across all three categories of organizational change. This site was characterized by broad participation in the planning process; strong and passionate leadership and staffing; a strategic partnership among highly committed and strategically placed individuals within city government, United Way and community activist groups; and creation of a new organization that served as a platform for obtaining grants and generating new programs to address unmet needs. Other more common patterns were for sites to achieve substantive progress in one or two areas, and moderate in the other(s), or limited progress in two categories and moderate in a third. Only two sites exhibited limited ratings across all three organizational change categories. One site had severe competing demands placed on its coordinator and a traditional service delivery orientation, while the other contended with frequent staffing turnover, erratic administrative support from its fiscal sponsor and conflict among its leadership.

Factors facilitating and inhibiting organizational change

Respondents were asked to comment on factors that facilitated organizational change in their CHCC projects. Five major themes emerged. First, respondents highlighted the reputation and influence of the CHCC coalitions, their leaders and associated organizational networks. As one coordinator in a rural area put it, '*we have a strong network of people that have been working there ... a lot of connections to different people in different aspects of the community*'. Second, organizational resources such as staff, facilities, the CHCC grant and technical assistance program, as well as other leveraged grants were viewed as instrumental in the creation of organizational change. A coordinator in an urban neighborhood commented, '*being able to invest in infrastructure, like being able to have a staff person who can come in and develop community leaders that go after the neighborhood matching funds, or pressure change at the schools [...J investing in the infrastructure really begets the other funding opportunities*'. A third theme was the value of knowledge derived from the assessment and action planning process. For example, in explaining how the planning process guided organizational change, one of the coordinators stated, '*... a lot of the research that was done beforehand to get*

these programs started [was instrumental]'. Commitment and persistence of the CHCC leaders emerged as a fourth theme. One community leader from a rural county highlighted people skills, '*somebody has to be good at networking. Somebody has to make eye contact with the people who make decisions, and somebody has to be at the table all the time*'. The final theme was an acknowledgement that timing mattered, particularly in terms of responding to real and compelling needs. As described by one coordinator in a rural municipality, '*it was just that combination of people in the right place at the right time*'.

Respondents were also asked to discuss factors that inhibited their ability to influence organizational change. Three major themes emerged. The first was the inter-related resource limitations of funding, time and staff. One coordinator from a rural municipality commented '*Let's face it. Certain programs have to have funding to exist*'. The second theme can be broadly classified as community context beyond the control of the CHCC projects. Examples include local politics and economics, local bureaucratic institutions and community history. A coordinator in an urban neighborhood stated, '*we don't have real responsive politicians in the area because they have to serve so many people, and our community's split up into a couple of different districts*'. Lastly, respondents shared challenges related to staffing and other management issues.

DISCUSSION

This study suggests that coalitions implementing a healthy cities and communities model, as practiced in California, have the potential to strengthen the infrastructure of a community's institutions to promote health. By offering a mechanism for creating a common vision, identifying assets and needs, and creating new linkages across sectors, organizations engaged in the CHCC process were in a stronger position to align their resources with community priorities and develop programs responsive to community needs. Across the 20 participating sites, significant numbers of new programs were developed, organizational policies and practices adopted, and new financial resources leveraged. These types of changes can be conceptualized as intermediate outcomes along a continuum of community change that is intended to lead to improved health status and quality of life (Paine-Andrews *et al.*, 2002; Chalmers *et al.*, 2003; Miller *et al.*, 2003; Chervin *et al.*, 2005). Alternatively, a strengthened organizational infrastructure can serve as an indicator of community capacity and resources to address health and social welfare priorities (Goodman *et al.*, 1998; Labonte and Laverack, 2001; Chaskin *et al.*, 2001; Labonte *et al.*, 2002; Chervin *et al.*, 2005; Chinman *et al.*, 2005).

Our findings are consistent with current views on the mechanisms through which organizations contribute to community capacity. Organizations can strengthen community capacity by becoming more responsive to community needs and assessing and incorporating community priorities into their own agendas, by engaging residents in governance, and by providing opportunities for community participation (Chaskin *et al.*, 2001; Kubisch *et al.*, 2002). Organizations can also contribute to community capacity by aligning their own resources with those of other community organizations to achieve a common goal, and they can attract new resources by justifying the need for a particular resource in their advocacy or grant writing efforts. Moreover, they serve as the primary mechanism through which philanthropies and government agencies can invest in a particular community (Chaskin *et al.*, 2001).

The CHCC coalitions were quite successful in leveraging financial resources from a variety of funding sources and in facilitating policy and practice changes in government agencies, school districts and private non-profit organizations. Rural sites were more successful than urban sites in leveraging funds on a per capita basis, in part because the same amount of funding could go further in smaller communities, and because there was less competition for funding in rural areas. Policy changes tended to be consistent with the principles of healthy cities and communities which emphasize inter-sectoral collaboration, a broad definition of health, widespread community involvement, systems change and capacity-building (Hancock, 1988; Norris and Pittman, 2000; Wolff, 2003). Many, for example, dealt with increased community input into decision-making or increased collaboration across community sectors. Others indicated a broadened definition of health and/or a commitment to a shared vision for the future of the community. In addition, many were associated with making services and programs more responsive to community needs, such as new locations and expanded outreach, and making facilities available for community groups.

Also of considerable note is the significant number of new and expanded programs. Many of these, of course, were directly related to the action plans developed as part of the CHCC grant. Others were in response to the needs identified in the community assessment process. Still others resulted from networking with organizations that had goals and interests compatible with the local CHCC coalitions. The most common programmatic area focused on the healthy development of youth and children. Other areas of program development were directly tied to capacity-building, with activities aimed at enhancing leadership skills among community residents, strengthening relationships among neighbors and providing opportunities for residents to get involved in the civic life of their communities.

Multiple case studies are appropriate for studying phenomena within real-life contexts, as with this evaluation of 20 different communities (Yin, 2003). Causal relationships, however, are difficult to document in complex and dynamic environments with multi-sectoral partnerships and broad agendas (Baume and Cooke, 1992; Cheadle *et al.*, 2003). Our findings relied heavily on the local coordinators' awareness of organizational changes and their judgments of which changes were influenced by the local CHCC projects. To the extent possible, we attempted to triangulate data sources using progress reports, albeit completed by coordinators, and interviews with community leaders in select sites. Nevertheless, our findings would be stronger if we had consistently assessed organizational change from multiple perspectives. A second limitation stems from the lack of baseline data on organizational change. We can document the number of changes, the type of changes and how the CHCC process contributed to these changes, but we cannot with certainty say that the CHCC coalition accelerated the rate of change. We also struggled with how to ensure comparability of data across sites. Our multi-method approach partially addressed this difficulty by allowing us to integrate qualitative findings into our magnitude assessments. Lastly, we should emphasize that these findings capture only a snapshot of results immediately following the end of the funding period for each of the CHCC grantees.

The magnitude rankings we present for programs and polices and the dollars leveraged should not be regarded as indicators of success or failure in the implementation of the CHCC process. Success is defined in many ways. We regard the organizational-level outcomes discussed here as indicators of the synergistic potential of broad-based, community-driven action planning processes aimed at improving health. Rather than an assessment of one coalition's performance compared to another, this multi-site evaluation sought to document the potential of the healthy cities and communities process, as well as similar initiatives, to activate and elevate the capacity of community institutions to function in health-promoting ways. Our evaluation demonstrates that modest levels of funding, development of a shared vision, technical support for broad-based action planning and implementing do-able health promotion projects can indeed produce significant changes in the landscape of community health through expanded financial resources, programs that touch people's sense of wellness and policies that foster the conditions for health.

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References:

Aronson, R., Norton, B. and Kegler, M. (2007) Achieving a broad view of health: findings from the California Healthy Cities and Communities evaluation. *Health Education and Behavior*, 34, 441–452.

Baum, F. and Cooke, R. (1992) Healthy Cities Australia: the evaluation of the pilot project in Noarlunga, South Australia. *Health Promotion International*, 7,181–193.

Chalmers, M., Housemann, R., Wiggs, I., Newcomb-Hagood, L., Malone, B. and Brownson, R. (2003) Process evaluation of a monitoring log system for community coalition activities: five-year results and lessons learned. *American Journal of Health Promotion*, 17,190–196.

Chaskin, R. J., Brown, P., Venkatesh, S. and Vidal, A. (2001) *Building Community Capacity*. Aldine de Gruyter, New York.

Cheadle, A., Beery, W., Greenwald, H., Nelson, G., Pearson, D. and Senter, S. (2003) Evaluating the California Wellness Foundation's Health Improvement Initiative: a logic model approach. *Health Promotion Practice*, 4,146–156.

Chervin, D., Philliber, P., Brindis, C., Chadwick, A., Revels, M., Kamin, S. et al. (2005) Community capacity building in CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy. *Journal of Adolescent Health*, 37, S11–S19.

Chinman, M., Hannah, G., Wandersman, A., Ebener, P., Hunter, S., Imm, P. et al. (2005) Developing a community science research agenda for building community capacity for effective preventive interventions. *American Journal of Community Psychology*, 35,143–157.

Connor, R. (2005) The Colorado Healthy Communities Initiative. *American Journal of Evaluation*, 26, 363–368.

Crisp, B., Serissen, H. and Duckett, S. (2000) Four approaches to capacity building in health: consequences for measurement and accountability. *Health Promotion International*, 15, 99–107.

Fawcett, S., Lewis, R., Paine-Andrews, A., Francisco, V., Richter, K., Williams, E. et al. (1997) Evaluating community coalitions for prevention of substance abuse: the case of Project Freedom. *Health Education and Behavior*, 24, 812–828.

Florin, P., Mitchell, R., Stevenson, J. and Klein, I. (2000) Predicting intermediate outcomes for prevention coalitions: A developmental perspective. *Evaluation and Program Planning*, 23, 341–346.

Flynn, B. (1996) Healthy Cities: toward worldwide health promotion. *Annual Review of Public Health*, 17, 299–309.

Flynn, B. C., Rider, M. S. and Bailey, W. W. (1992) Developing community leadership in Healthy Cities: The Indiana Model. *Nursing Outlook*, 40,121–126.

Francisco, V., Paine, A. and Fawcett, S. (1993) A methodology for monitoring and evaluating community health coalitions. *Health Education Research*, 8, 403–416.

Goodman, R., Speers, M., McLeroy, K. et al. (1998) An attempt to identify and define the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior*, 25, 258–278.

Hancock, T. (1988) The future of public health in Canada: Developing healthy communities. *Canadian Journal of Public Health*, 79, 416–419.

Hancock, T. and Duhl, L. (1986) *Promoting Health in the Urban Context*. WHO Healthy Cities Paper No. 1, WHO Regional Office for Europe, Copenhagen.

Hays, C., Hays, S., DeVille, J. and Mulhall, P. (2000) Capacity for effectiveness: the relationship between coalition structure and community impact. *Evaluation and Program Planning*, 23, 373–379.

Kegler, M., Twiss, J. and Look, V. (2000) Assessing community change at multiple levels: the genesis of an evaluation framework for the California Healthy Cities Project. *Health Education and Behavior*, 27,760–779.

Kegler, M., Norton, B. and Aronson, R. (2007) Skill improvement among coalition members in the California Healthy Cities and Communities Program. *Health Education Research*, 22, 450–457.

Kegler, M., Norton, B. and Aronson, R., Strengthening community leadership: evaluation findings from the California Healthy Cities and Communities Program. *Health Promotion Practice*, in press.

Kubisch, A., Auspos, P., Brown, P., Chaskin, R., Fulbright-Anderson, K. and Hamilton, R. (2002) *Voices from the Field II: Reflections on Comprehensive Community Change*. The Aspen Institute, Washington, DC.

Kurland, J. (2000) Editorial. Making healthy communities. *Public Health Reports*, 115, 107.

Labonte, R. and Laverack, G. (2001) Capacity-building in Health Promotion, Part 1: For Whom? And for what Purpose? *Critical Public Health*, 11, 111–127.

Labonte, R., Woodard, G., Chad, K. and Laverack, G. (2002) Community capacity building: a parallel track for health promotion programs. *Canadian Journal of Public Health*, 93,181–182.

Lee, P., Fuccillo, R. and Wolff, T. (2000) Key components of a statewide healthy communities effort. *Public Health Reports*, 115,134–138.

McLeroy, K., Bibeau, D., Steckler, A. and Glanz, K. (1988) An ecological perspective on health promotion programs. *Health Education Quarterly*, 15, 351–377.

Miles, M. B. and Huberman, A. M. (1994) *Qualitative Data Analysis: a Sourcebook of New Methods*. Sage Publishing, Beverly Hills, California.

Miller, R., Bedney, B., Guenther-Grey, C. and the City Project Study Team. (2003) Assessing organizational capacity to deliver HIV prevention services collaboratively: Tales from the field. *Health Education and Behavior*, 30, 582–600.

Norris, T. and Pittman, M. (2000) The healthy communities movement and the coalition for healthier cities and communities. *Public Health Reports*, 115, 118–124.

Paine-Andrews, A., Fisher, J., Berkely, P., Fawcett, S., Williams, E., Lewis, R. et al. (2002) Analyzing the contribution of community change to population health outcomes in an adolescent pregnancy prevention initiative. *Health Education and Behavior*, 29, 183–193.

Patton, M. (2002) *Qualitative Research and Evaluation Methods*. third edition, Sage Publications, Thousand Oaks, CA.

Provan, K., Veazie, M., Teufel-Shone, N. and Huddleston, C. (2004) Network analysis as a tool for assessing and building community capacity for provision of chronic disease services. *Health Promotion Practice*, 5,174–181.

Richards, L. (2002) *Using N6 in Qualitative Research*. QSR International Pty Ltd, Melbourne, Australia.

Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Sage, Publications, Newbury Park, CA.

Thompson, B. and Kinne, S. (1999) Social change theory: applications to community health. In Bracht, N. (eds), *Health Promotion at the Community Level*. Sage Publications, Thousand Oaks, pp. 29–46.

Twiss, J. (1997) California's Healthy Cities: governance in action. *National Civic Review*, 86, 81–91.

Twiss, J., Duma, S., Look, V., Shaffer, G. and Watkins, A. (2000) Twelve years and counting: California Healthy Cities and Communities. *Public Health Reports*, 115, 125–134.

Wallerstein, N. (2000) A participatory evaluation model for healthy communities: developing indicators for New Mexico. *Public Health Reports*, 115, 199–204.

Weisbrod, R., Pirie, P. and Bracht, N. (1992) Impact of a community health promotion program on existing organizations: The Minnesota Heart Health Program. *Social Science Medicine*, 34, 639–648.

Wolff, T. (2003) The healthy communities movement: a time for transformation. *National Civic Review*, 92, 95–111.

Yin, R. (2003) *Case Study Research: Design and Methods.* 3rd edition, Sage Publications, Thousand Oaks, CA.