CHAPTER 15

IMPROVING HEALTH THROUGH COMMUNITY ENGAGEMENT, COMMUNITY ORGANIZATION, AND COMMUNITY BUILDING

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The concept of community engagement, viewed through its multiple lenses, is rooted in social justice and community change processes. In the 1997 Centers for Disease Control and Prevention (CDC) publication *Principles of Community Engagement*, *community engagement* was defined as "the *process* of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being" (CDC, 1997, p. 9). The term has gained traction in recent years, especially with the growth of the Clinical and Translational Science Awards program (www.ctsacentral.org), and draws from three major, often overlapping fields and their histories: community organization and community building, coalitions and partnerships, and community-based participatory research.

Community organizing is defined as the process by which community groups are helped to identify common problems or change targets, mobilize resources, and develop and implement strategies to reach their collective goals. Though it is different from the general sentiment of *community engagement*, it also incorporates conflict

KEY POINTS

This chapter will:

- **Provide a brief history of community engagement, incorporating community organization and community building, coalitions and partnerships, and community-based participatory research (CBPR).**
- **Examine the concept of community for informing community engagement.**
- **Explore key concepts and principles of community engagement.**
- **Present models of community organization and building, coalitions, and CBPR, as a backdrop to community engagement.**
- **Present a case study application of community engagement that integrates community organizing and building, coalition building, and CBPR.**
- **Discuss measurement and evaluation issues.**

and confrontation strategies as well as collaborative ones (Minkler & Wallerstein, 2012). The related concept of *community building* is less a strategic approach than an orientation to community that engages and collectively *builds* capacity in the process (Walter & Hyde, 2012). Community organization and community building practice include, as their base, principles of social action and social justice.

Coalitions and partnerships, formed as people and organizations work together to solve problems, are increasingly common (Butterfoss, 2007), and provide a fundamental base for community engagement. *Community-based participatory research* (CBPR) and *community-engaged research* (CEnR) add a research focus, with a grounding in partner relationships among community, academic, and/or agency stakeholders that characterizes the entire research process. In public health contexts, CBPR has at its core a collective, shared focus on overcoming social and health inequities through community members partnering with researchers and organizational representatives and building on community strengths and priorities to apply research for the goals of social change (Israel, Eng, Schulz, & Parker, 2012; Minkler, Wallerstein, & Wilson, 2008).

This chapter will introduce concepts and methods of community engagement, broadening and building on earlier work on community organization and community building (Minkler et al., 2008) and emphasizing the range and effectiveness of community partnerships. After examining the concept of community, we then turn to the history of community engagement, the concepts and principles of engagement, and a discussion of diverse models from complementary literatures. We present one illustrative application of concepts and models, and conclude with a discussion of measurement issues in assessing engagement effectiveness.

The Concept of Community

Although typically thought of in geographic terms, communities may also be based on shared interests or characteristics, such as race or ethnicity, sexual orientation, or occupation. Communities have been defined variously as (1) *functional spatial units* meeting basic needs for sustenance, (2) *units of patterned social interaction*, (3) *symbolic units of collective identity*, and/or social units where people come together politically to make change (Minkler et al., 2008).

Several key perspectives are relevant to understanding the concept of community. The *ecological systems perspective* (see Chapter Three for a discussion of ecological models) is particularly useful in the study of autonomous geographic communities, focusing on population characteristics, such as size, density, and heterogeneity; the physical environment; the social organization of the community; and the technological forces affecting it. Therefore, "for the community to function well, each part has to carry out its role in relation to the whole organism" (Clinical and Translational Science Awards [CTSA] Consortium, Community Engagement Key Function Committee, & Task Force on the Principles of Community Engagement, 2011, p. 5).

In contrast, the *social systems perspective*, classically articulated by Warren (1963), focuses primarily on formal and informal organizations that operate dynamically within a given community, exploring the interactions of community subsystems, both horizontally, within

the community, and vertically, as they relate to other systems of power. The social systems perspective further suggests that getting to know the networks through which a community's members, organizations, and leaders interact is imperative to further strengthening that community and working better with it (CTSA Consortium et al., 2011; Minkler & Wallerstein, 2012).

Clearly, a person's perspective on community influences his or her view of the community engagement process. Community development specialists often have focused on *geographic communities*. In contrast, proponents of a broader social action approach (Alinsky, 1972) have encouraged organizing around *issues*, such as public housing and unemployment, recognizing the tremendous impact of those larger socioeconomic issues on local communities.

Yet other perspectives also influence our ways of thinking about and approaching community (Gutiérrez & Lewis, 2012). Chavez, Minkler, Wallerstein, and Spencer (2010), for example, have emphasized the importance of a *cultural/historical perspective*, noting that an appreciation of the unique characteristics and histories of communities of color should be a major consideration. Cornell West (1993) has argued that in African American communities market exploitation led to a shattering of religious and civic organizations that had historically buffered these communities from hopelessness. He calls for community change through recreating a sense of agency and political resistance based on "subversive memory—the best of one's past without romantic nostalgia" (West, 1993, p. 19). Likewise, in American Indian communities today there is a burgeoning cultural renewal movement that embraces organizing and healing from intergenerational historical traumas that were wrought by the dominant society (Walters, Beltran, Huh, & Evans-Campbell, 2011). A view of community with this perspective would support building on social networks and strengths, emphasizing self-determination and empowerment (Chavez et al., 2010; Gutiérrez & Lewis, 2012).

Of growing importance is the *virtual perspective*, which recognizes that individuals increasingly rely on "computer-mediated communications to access information, meet people and make decisions that affect their lives" (Kozinets, 2002; CTSA Consortium et al., 2011). Facebook alone now has more than a billion registered users, and if a nation, would be the third most populous in the world (Statistic Brain, 2015). With the unprecedented ease and frequency of forming new relationships, these virtual communities cannot be ignored (Bazell & Wong, 2012; Kanter & Fine, 2010). Online groups that both build and support communities (e.g., of people with disabilities, LGBT youth, or Asian Pacific Islanders who have Hepatitis B, or other groups of people who share identities, interests, or often-stigmatizing conditions) are growing in both size and sophistication (Bazell & Wong, 2012).

Finally, an often-overlooked perspective highlighted in the community engagement literature is the *individual perspective*. This view posits that individuals define their community membership(s) with multiple or intersecting identities that go beyond the single definition of community upon which researchers and community engagement practitioners tend to rely (CTSA Consortium et al., 2011). For people who are seeking community engagement, understanding how individuals and communities view themselves through multiple lenses is critical for effective practice.

Histories of Community Engagement

Community engagement draws from many histories. The term *community organization* was coined in the late 1800s by American social workers who coordinated services, such as settlement houses, for newly arrived immigrants and the poor (Garvin & Cox, 2001). While a more complete discussion of community organizing history can be found elsewhere (see Minkler & Wallerstein, 2012), some important milestones in this history are the post-Reconstruction period in which African Americans organized to salvage newly won rights, the Populist agrarian movement, and the labor movement of the 1930s and1940s (Garvin & Cox, 2001). Originally a consensus model, by the 1950s, with labor struggles gaining attention, community organizing began to stress confrontation and conflict strategies for social change (Alinsky, 1972). Since the 1950s, strategies and tactics of community organization increasingly have been applied to achieve broader social change objectives: for example, by the civil rights, women's rights, gay rights, and disability rights movements and even by the New Right in its organizing to ban abortions and gay marriage. From the mid-1990s on, groups across the political spectrum have built online communities, organizing support on a mass scale (Smith, 2011).

A complementary history grounds community engagement in the *participation* strategies of the World Health Organization (WHO), whose 1948 Constitution stated that "informed opinion and active cooperation on the part of the public are of the utmost importance" in improving health. This constitution was followed by other key documents emphasizing participation. In 1978, the Declaration of Alma-Ata, signed at the International Conference on Primary Health Care, convened by WHO and UNICEF, advocated primary health care for all, with a call for participation by community members in the planning and implementation of their health care (www.who.int/publications/almaata_declaration_en.pdf). A decade later, the Ottawa Charter for Health Promotion, signed at the First International Conference on Health Promotion, also convened by WHO, advocated community action as one of five priorities (www.who.int/healthpromotion/conferences/previous/ottawa/en). This human rights approach, emphasized in later health promotion conferences (Fawcett et al., 2010) and by the WHO Commission on Social Determinants (WHO, 2015), envisions health equity through empowerment and participation by all (Wallerstein, Mendes, Minkler, & Akerman, 2011).

In the United States, community participation terminology was embraced in the 1960s, with John F. Kennedy's New Frontier and Lyndon Johnson's War on Poverty supporting federal mandates for "maximum feasible participation," including the *community health center* movement (Geiger, 2005). The Centers for Disease Control and Prevention (CDC) has long embraced participatory planning and program initiatives, with such programs and publications as the Planned Approach to Community Health, the Prevention Research Centers, the REACH initiative for racial and ethnic equity; the first edition of *Principles of Community Engagement*; and recently the Community Transformation Grants (www.cdc.gov/communitytransformation). In 1995, the National Institute of Environmental Health Sciences initiated sustained funding across multiple institutes for community-based participatory research.

In a new, major National Institutes of Health (NIH) initiative that supports community engagement, the Community Engagement Key Functions Committee of the NIH's Clinical and Translational Science Awards (CTSA) consortium has made inroads in community-engaged approaches within academic medical institutions and primary health systems (Carter-Edwards et al., 2013; Westfall et al., 2012). The CTSAs initially were developed to accelerate translation of academic medical research to clinical applications and to maximize improvement in individual and population health. With the first CTSAs funded in 2006, today there are sixty awards across thirty states and the District of Columbia, and they are coordinated through the NIH's new National Center for Advancing Translational Sciences (NCATS) (www.ncats.nih.gov/research/cts/ctsa/about/about.html).

While CTSAs initially were not required to engage communities in their efforts, many did, and community engagement has evolved to become an integral component of the CTSA program, as community efforts have bolstered translational medical and community-based research activities (Katz et al., 2011). The CTSA consortium's Community Engagement Key Function Committee seeks to, among other things, implement a broad plan of community and practice engagement to ultimately "enhance the health of communities and the nation" (CTSA Strategic Goal 4). The 2010 signing of the Affordable Care Act (ACA) into law is strengthening this paradigm shift so that national priorities are focusing much more on prevention; on community, stakeholder, and patient participation; and on systemwide coordinated health care (Selby, Beal, & Frank, 2012; www.pcori.org).

In practice, community engagement efforts are still developing. The revised *Principles of Community Engagement* (CTSA Consortium et al., 2011) offers a continuum of engagement as a framework to guide efforts; it begins with minimal community outreach on one end of the spectrum and moves through consultation and collaboration to a shared leadership approach. Progress at the individual CTSA level has been incremental and varied, as some academic medical institutions have integrated lay community members and organizations as partners in the research decision-making process, while others have relationships but not bidirectional research relationships with community organizations and health systems, and still others are just learning how to identify their community partners. These differences reflect the need for a common understanding and appreciation across CTSAs of principles of community engagement, not only by investigators but also by their infrastructure leadership. Furthermore, there is very little research on the prevalence of community engagement in research, particularly in clinical and translational studies funded by the NIH (Hood, Brewer, Jackson, & Wewers, 2010). However, the institutionalization of community engagement is slowly getting under way.

The Institute of Medicine's 2013 report on the CTSA program, commissioned by the National Institutes of Health in response to a congressional request, provides seven high-level recommendations, one of which involves community engagement, which also is one of the three cross-cutting domains in the report (Institute of Medicine [IOM], 2013, p. 116). The sixth recommendation, *to ensure community engagement in all phases of research,* states that the NCATS and the CTSA program should define community engagement broadly; ensure active

and substantive community stakeholder participation throughout the research and leadership process; define and clearly communicate community engagement goals, expectations, and best practices; and explore opportunities and incentives to engage a more diverse community (IOM, 2013, p. 127).

The IOM committee defines a *community* as all stakeholders in the clinical and translational research process, people who "seek and provide health care in community, academic, and private settings, as well as individuals and organizations working in communities to improve the health and well-being of local populations" (IOM, 2013, p. 116). This definition offers a fairly broad view of population health, but it remains largely a clinical perspective, with its implied emphasis on health care within multiple settings. It is different from a public health approach, where social determinants and other environmental and policy conditions are recognized as key socioecological contributors to population health and well-being. Both of these approaches to community engagement are necessary for full research translation.

Because community engagement is new to many researchers, barriers persist, including lack of understanding about the benefits of community engagement and the presence of some academic cultures that discount partnership building. From the community perspective, there may be issues of mistrust owing to histories of manipulation or disrespect, or lack of adequate funding to compensate and provide training for community partners.

There are programs at the NIH that can help serve as models for the CTSAs. The National Cancer Institute's Community Networks Program Centers, which seek to improve access to beneficial cancer interventions and treatments in communities in order to reduce health disparities, provide communities with the resources they need using a community-based participatory research approach (www.cancer.gov/aboutnci/organization/crchd/disparities research/cnpc). The National Institute on Minority Health and Health Disparities sponsors Research Centers in Minority Institutions and Centers of Excellence to Reduce Health Disparities that provide ongoing collaborations with the CTSAs. Across the country, established CBPR partnerships have created successful models as well.

While the inclusion of all stakeholders is important for the successful streamlining of the research process, it is critical that lay community members, those traditionally not a part of the decision-making process, be fully engaged. Increasingly, research teams have come to see the value of the *bridging* social capital function of partners—whether they are university staff or key community members who are part of advisory committees—who have connections to or come from the community where the research is taking place. The people who best perform this bridging function often have the capacity to work across institutional and racial or ethnic cultures and across power relationships to promote greater equality of participation among diverse stakeholders (Muhammad et al., 2014).

Although clinical and public health approaches to community engagement have increased, community engagement is still a contested concept with differing definitions, perceptions, and understandings. Arnstein's classic Ladder of Citizen Participation (Arnstein, 1969) and the newer public health ladder (Morgan & Lifshay, 2006) wisely underline the potential for manipulation, and remind those of us in the academy about the importance of self-reflection regarding our own actions in our efforts to promote successful community engagement.

In sum, community engagement today is viewed primarily as a consensus-building orientation. The possibility of moving from outreach to the shared leadership and partnered CBPR end of the continuum depends on embracing the concepts and principles of empowerment, inclusivity, collaborative action, and health equity, which were also hallmarks of the early community organization traditions.

Community Engagement Concepts and Principles

Concepts and principles of community engagement have guided public health professionals and community leaders with a science base as well as with core values and practical strategies for engaging the public in decision making and social action. Not merely technical or prescriptive processes, these concepts and principles place respect and integrity at the forefront of work with communities. Dorothy Nyswander's (1956) well-known axiom "start where the people are" centered the field of health education in community engagement, making that engagement one of the field's most fundamental principles. During the development of contributing fields, various field-specific sets of principles have been developed, such as the principles of community organizing (Alinsky, 1972), of environmental justice (*Principles of Environmental Justice*, 1991), and of bidirectional community engagement (CTSA Consortium et al., 2011), and for community-engaged research, we have the now classic principles of CBPR (Israel, Schulz, Parker, & Becker, 1998) and principles for CBPR with indigenous peoples (Walters et al., 2009). Each of these sets of principles upholds a natural process of working with community, whether in research or practice, and can be applied to partnerships across the community engagement continuum.

This chapter brings together four overarching concepts, with principles embedded in each concept (see Table 15.1): (1) community capacity, with principles of recognizing the community as a unit of identity and building on community strengths; (2) empowerment and critical consciousness, with principles of promoting co-learning and cultural humility, involving cyclical and iterative processes, and integrating knowledge and action, and a new principle of practicing collaborative mentorship that honors diversity; (3) participation and relevance, with principles of facilitating equitable involvement of all partners in practice and research and undertaking long-term commitment; and (4) recognition of inequities as the major target of change.

Community Capacity

Community capacity is defined as "the characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems" (Goodman et al., 1998, p. 259). These characteristics have multiple dimensions: active participation, leadership, rich support networks, skills and resources, critical reflection, sense of community, understanding of history, articulation of values, and access to power (Goodman et al., 1998).

Underlying community capacity, and the related concepts of community competence, social capital, and community empowerment, is the principle of community as a unit of identity. This involves relationships based on commonalities, and which can hold the greatest

Table 15.1 Key Concepts and Principles in Community Engagement

Key Concepts	Key Definition	Principles	Application
Community capacity	Community characteristics affecting a community's ability to identify problems and then to mobilize and address them.	Community is a unit of identity. Capacity builds on community strengths.	Community members actively participate in identifying and solving their problems and become better able to address future problems collaboratively.
Empowerment	A social action process for people to gain mastery over their lives and the lives of their communities.	Promote co-learning. Integrate knowledge and action.	Community members expand their power or challenge power structures to create desired changes.
Critical consciousness	A consciousness based on praxis: the cycle of reflection and action toward social change.	Involve cyclical and iterative processes. Practice collaborative mentorship that honors diversity and cultural humility.	People are engaged in listening and dialogue and also in action that links root causes and community actions.
Participation and relevance	Community organizing should "start where the people are" and engage community members as equals in their own priorities.	Facilitate equitable involvement of all partners in all stages of practice and research. Undertake long-term commitment. Ensure cultural relevance.	Community members create their own agenda based on felt needs, shared power, and awareness of resources.
Health equity	The opportunity for all to obtain their full health potential regardless of social position or socially determined circumstance.	Address inequitable conditions that create health disparities. Identify social determinants of health.	Resources are allocated to community-, policy-, and system-level changes that challenge inequitable conditions that cause ill health.

potential for being a "community as the unit of solution" (Steckler, Dawson, Israel, & Eng, 1993). Although a community may benefit from academic or health professional skills and resources that exist outside its community of identity, building on community strengths (a second principle), through involving community organizations and leaders, can enhance the connections of those with shared interests (Minkler & Wallerstein, 2012; Israel et al., 1998).

Social networks, the webs of relationships in which people are embedded, and social supports, the tangible and intangible resources they give and receive through these networks, are important for capacity building (also see Chapter Eleven). Strengthening natural helpers or leaders, found through social networks, is key to building capacity and effectiveness. As Gutiérrez and Lewis (2012) suggest, leadership development may be especially important in communities of color, given that outreach efforts often treat such communities as targets, rather than as active participants in change.

Empowerment and Critical Consciousness

Empowerment and critical consciousness are deeply embedded within community engagement. While *empowerment* has been justifiably criticized as a catchall term in social science

(Rappaport, 1984), it remains a central tenet of community organization, community building, and community engagement. Broadly defined, empowerment is a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life (Rappaport, 1984; Wallerstein, 2006). As a theory and a methodology, community empowerment involves both processes and outcomes, and has a focus on transforming power relations for individuals, the organizations of which they are a part, and the community social structure itself. For individuals, psychological empowerment addresses their perceived control, critical consciousness, political efficacy, and participation in change (Peterson et al., 2006). Organizational empowerment incorporates advocacy processes as well as organizational effectiveness in policy change (Laverack, 2007). Community empowerment outcomes include an increased sense of community, or sense of belonging to and identification with a group or geographic area; community capacity; and actual changes in policies, transformed conditions, or increased resources, all of which can contribute to reducing health inequities (Wallerstein, 2006).

Empowerment involves multiple principles. Promoting co-learning emphasizes the reciprocal exchange of skills, knowledge, and capacity among all involved, recognizing that all bring diverse skills, expertise, and experiences to partnership processes (Israel et al., 1998). The process of engagement is a dialectic exchange that challenges and transforms knowledge, promotes critical consciousness (Freire, 1970), and advances the collective power of partnership.

Co-learning, along with the principle of involving cyclical and iterative processes, builds from the dialogical approach of Paulo Freire (1970), with its accent on praxis, the cycle of reflection and action that involves listening, critical dialogue, and action based on reflection, and then cycling back to listening (Wallerstein & Auerbach, 2004). Many would argue that co-learning and empowerment are not possible without the principle of cultural humility, defined as an openness to others' cultures and an ability to reflect on and to seek to redress our own positions of power in relation to community partners (Chavez et al., 2010).

The principle of integrating knowledge and action is aimed at balancing evidence-based knowledge with practice- and community-based knowledge in a bidirectional process that creates action to produce community benefit. Community members provide knowledge informed by their cultural and social contexts; practitioners and researchers bring various skill sets (e.g., for planning, evaluation, and research) and evidence-based approaches to the collective table (Andrews et al., 2012). By engaging community knowledge, the potential for program sustainability and policy actions based on community priorities grows.

An emerging principle of collaborative mentorship honors diversity and emphasizes the exchange of knowledge and experience that fosters co-learning and mentoring among all partners. Mentorship becomes multidimensional and nonhierarchical and shows respect for multiple sources of knowledge. Rather than accepting the traditional view of senior professionals mentoring students, junior staff, or community members, collaborative mentorship suggests the importance of using multiple types of mentoring—top-down, bottom-up, and peer mentoring—an approach that recognizes epistemological diversity and the value of listening deeply, enabling respect for the perspectives and values of each partner (Duran et al., 2012).

Participation and Relevance

The concepts of participation and relevance represent the core value of starting "where the people are" (Nyswander, 1956) and working with communities in ways that acknowledge mutual strengths and the skills of community partners. This implies the principle of involving community in all stages of engagement, from naming the problem and planning for change to implementing and evaluating plans and strategies. Within this principle is the recognition that change is not time bound but requires long-term commitment to tackle "wicked," that is, intractable and multilayered, social and health problems.

One of the most important steps in community engagement involves effectively differentiating between problems that are troubling and issues the community feels strongly about (Staples, 2004). Various methods may be used to help a community group obtain the data needed to document issues while ensuring those issues' relevance. Face-to-face data collection processes include focus groups, door-to-door surveys, and interviews, which also can be useful in assessing felt needs and increasing a sense of participation (Duran et al., 2012). Freire's (1970) dialogical, problem-posing methodology has proven especially helpful for engaging participants in identifying themes that elicit social and emotional involvement, followed by social action and reflection (Wallerstein & Auerbach, 2004).

Photovoice is an approach that emphasizes community strengths along with issue selection (Catalani & Minkler, 2010; Wang & Pies, 2008). Researchers or practitioners provide cameras and skills training to community residents who then use the cameras to convey their own images of their community, including community assets and problems. Photovoice is often used with problem-posing questions. Participants work together to select the pictures that best capture their collective wisdom, and use these to tell their stories and to stimulate change through local organizing and institutional- and policy-level action.

The Internet can be used to facilitate participation and ensure relevance when assessing community needs and strengths, building community, and conducting advocacy (Bazell & Wong, 2012). Two initiatives in Indian country highlight the capacity for Internet tools to inspire, educate, and connect communities that are dispersed and often geographically isolated. Just Move it (JMI) (www.justmoveit.org/jmi), a program initiated by the Health Promotion/Disease Prevention program of the Indian Health Service, and now also an initiative of the Healthy Native Communities Partnership (HNCP) and the Assembly of First Nations in Canada, has a goal of promoting physical activity among one million indigenous people. JMI's website offers health promotion staff and community members opportunities to promote their events, share success stories, and document their achievements.

Similarly, the Healthy Native Communities Fellowship (HNCF), (www.hncpartners.org /HNCP/Fellowship.html), with an organizational trajectory similar to JMI's, has provided nine years of leadership training to strengthen teams of Fellows as change agents for promoting health and wellness within their communities and across regions. Since 2005, 119 teams and 299 Fellows from all twelve Indian Health Service areas have participated. An interactive "Fellow Space" has been used in between weeklong trainings to facilitate blogging by Fellows, teams, and alumni in order to maintain connections, share achievements, receive educational materials, and promote strategic thinking and planning across teams.

In one of the largest shared spaces for educational materials on community organization and planning for health, Steve Fawcett and his colleagues created the Community Tool Box (ctb.ku.edu), close to 9,000 pages in length, which is organized around core competencies, ranging from community assessment, to coalition development, policy advocacy, and evaluation. As part of an international Pan American Health Organization collaboration, the Community Tool Box is being translated into Spanish, with plans for a Portuguese translation as well. While there are still significant barriers to Internet access for poor and rural communities, promising efforts to close the digital divide are underway, with groups like ZeroDivide (www.zerodivide.org) and the Digital Divide Network (www.digitaldivide.net) providing searchable geographic sites for local technology programs and resources and in other ways attempting to reach and assist those who remain unconnected (Bazell & Wong, 2012). Underscoring all these methods is the fact that they are useful only to the extent that they enable the discovery of the real issues of concern to each community.

Recognition of Inequities

With firm evidence of social and health disparities among racial and ethnic minorities and other vulnerable populations, public health practitioners and researchers have increased efforts to eliminate health and social inequities. The focus on disparities and inequities is not new to community organizing; however, it has gained momentum through the building of the evidence base for these social and structural inequities (Brennan Ramirez, Baker, & Metzler, 2008; Wallerstein, Yen, & Syme, 2011). There are persistent challenges to addressing key determinants such as institutionalized racism, discrimination, or differences in educational resources and opportunities, however. Capacity-building partnerships that start where the people are; view knowledge and skills not as a hierarchy but as multileveled and multiple-sourced; and make community participation, knowledge, and power relevant from a strengths-based perspective, rather than a deficit perspective, can help to promote equity. By embracing these concepts and principles, community engagement can build the trust and community mobilization needed to make a difference in community lives and health.

Community Organization and Community-Building Models

Although community organization and community building are frequently treated as though they were a single model of practice, several typologies have been developed. The best known is the work of renowned community organization theorist Jack Rothman (2007) and consists of three distinct but overlapping models of practice. Originally described as locality development, social planning, and social action, the language and sophistication of these three models have subsequently been broadened (Rothman, 2007).

Community capacity development stresses cooperation as an organizing approach, with building group identity and problem solving as key goals. This revised nomenclature avoids the narrower geographic focus implied by *locality development* and strongly incorporates community building. *Social planning and policy* stresses the use of data and rational-empirical problem solving, while also making room for participatory planning and policy development,

in keeping with the spirit of true community organization; whereas the earlier term, *social planning*, generally offered by professionals was more limited. Finally, *social advocacy*, like its predecessor, *social action*, emphasizes the use of pressure tactics, including confrontation, to help bring about concrete changes to redress power imbalances, but is more in keeping with the social change tactics and strategies being used in the early twenty-first century (Rothman, 2007). These include both neighborhood actions and far larger efforts, often aided by the Internet, to foster national and even global change programs, such as efforts to address refugee relief and climate change.

Rothman originally presented the models as three ideal types, but with mixing among them, either at the outset or over time. His later work elaborated on mixed forms, highlighting a *predominant mode* and two other *composite models* (Rothman, 2007). Feminist community organizing, for example, may combine the goals of social advocacy organizing with methods that are consistent with community capacity development (Hyde, 2005; Rothman, 2007). Similarly, the Healthy Heartlands Initiative being implemented across five Midwestern states combines faith-based community capacity *development, planning,* and *policy* (or "setting the table with technical experts") with social advocacy that engages legislators and other key players in promoting racial and health equity (Blackwell et al., 2012).

Although not a strategic model per se, Walter and Hyde's (2012) community-building approach places the *community*, rather than the *community organizer*, at the center of practice. Partially emphasizing self-help, this perspective extends beyond community development, which is often externally driven and may implicitly accept the status quo, and focuses instead on creating healthy and more equal power relations (Hyde, 2005; Walter & Hyde, 2012). Though it includes many steps from traditional organizing (e.g., clarifying a community's purpose and building a power base), it puts the heaviest accent on community leadership and empowerment, rather than merely "community betterment" (Wolff, 2010). McKnight's (1987) notion of community regeneration has at its heart enabling people to contribute their gifts, which represent the building blocks a community can use to care for its members. Finally, a macro-conception of community building also emphasizes regional economic development and federal and state policy-level reinvestment in local communities as critical (Blackwell & Colmenar, 2000).

Feminists and scholars of color also point to particulars of organizing within their communities (Gutiérrez & Lewis, 2012; Rivera & Erlich, 1995). As Hyde (2005) points out, feminist organizing need not address "quintessentially feminist issues" such as gender violence or pay equity; rather it's the empowering aspects that make an organizing effort feminist. Organizing by and with people of color focuses attention on the centrality of cultural, historical, racial or ethnic, and/or linguistic identities. It is also important to acknowledge conflict as a necessary part of cross-cultural work (Gutiérrez & Lewis, 2012), and for some theorists, it is important to limit primary levels of involvement to organizers who share racial or ethnic and other identifiers with communities (Rivera & Erlich, 1995).

In sum, several models of community organization and community building have emerged within the last two decades to complement earlier organizing approaches. In Figure 15.1, we integrate models, presenting a typology that incorporates both needs- and strengths-based approaches. Along the needs-based axis, *community development,*

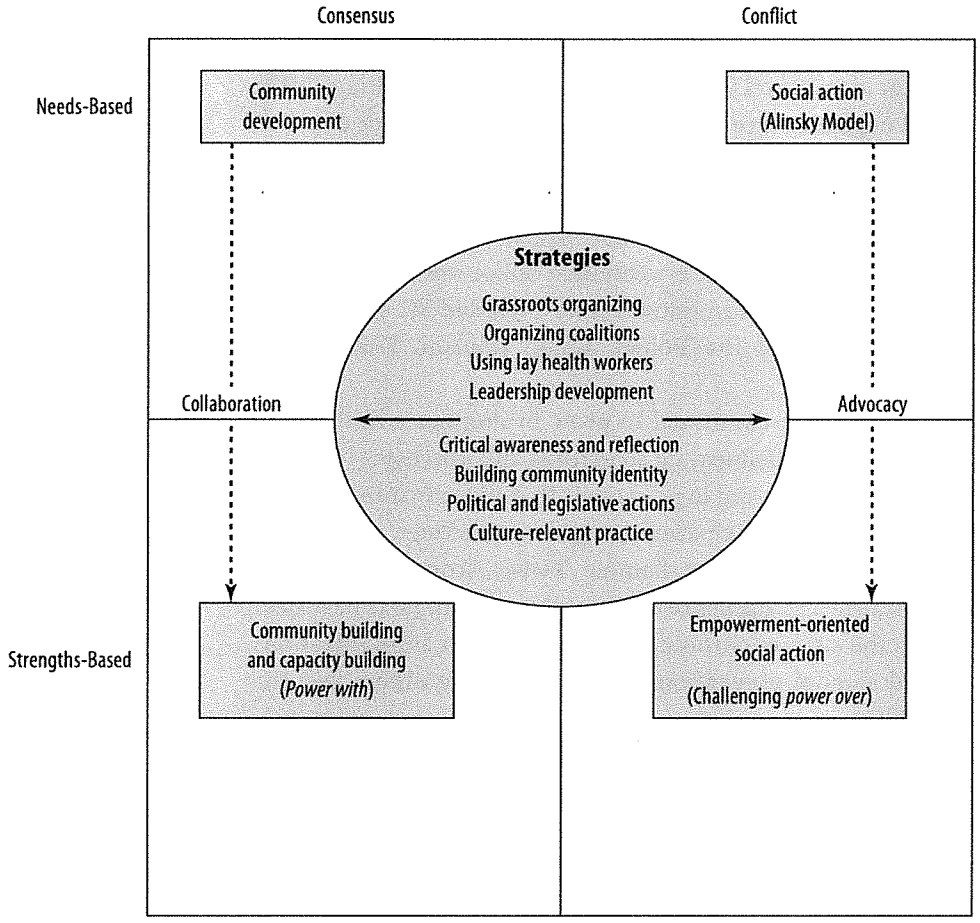

Figure 15.1 Community Organization and Community-Building Typology

as primarily a consensus model, is contrasted with Alinsky's *social action* conflict-based model. The newer strength-based models contrast community capacity building with an empowerment-oriented social action approach. When we look at primary strategies, we see that consensus approaches, whether needs- or strengths-based, primarily use collaboration strategies, whereas conflict approaches use advocacy and ally building to support advocacy efforts. Several concepts span these two strengths-based approaches, such as community competence, leadership development, and the multiple perspectives on gaining power. Much organizing uses combinations of strategies at different times during an organizing campaign and the community engagement process.

Coalition and Partnership-Building Models

Coalitions represent intentional processes of community engagement of individuals and organizations, ranging from formation to institutionalization of coalition infrastructures through sharing resources and streamlining efforts (Butterfoss, 2007; Minkler & Wallerstein, 2012).

Coalitions work within communities of identity to build community capacity by encouraging community members to develop leadership and research skills within the social and health context. Coalitions can mobilize change at any level (Nelson, Salmon, Altman, & Sprigg, 2012), and are dynamic, requiring continued negotiation to achieve or maintain the balance of power and privilege (CTSA Consortium et al., 2011).

Over the last two decades, publicly funded coalitions have included the American Stop Smoking Intervention Study (ASSIST), Racial and Ethnic Approaches to Community Health (REACH), Steps to a Healthier US, and diverse substance abuse and healthy community coalitions. Foundation-supported coalition initiatives have included W. K. Kellogg's Community-Based Public Health Initiative, and the Robert Wood Johnson Foundation's Fighting Back and Allies Against Asthma.

As health coalitions and partnerships have continued to grow in number and diversity, research on their effectiveness has shifted from delineating structures and processes (Granner & Sharpe, 2004; Zakocs & Edwards, 2006) to creating logic models that identify intermediate-term systems change in community capacities, participation, programs, practices, and policies linked to health outcomes (Cheadle et al., 2003; Kegler, Painter, Twiss, Aronson, & Norton, 2009; Sanchez, Carrillo, & Wallerstein, 2011). Examples of coalitions' health impacts have been increasing throughout the literature in the areas of chronic disease prevention, immunizations, substance abuse, teen pregnancy, and alcohol prevention coalitions, among others (see this book's supplementary web materials).

Allies Against Asthma (AAA), funded in 2000 by the Robert Wood Johnson Foundation, illustrates how community partnerships have come to recognize the importance of targeting systems change (AAA, 2011). Community organizations, health care agencies, and universities partnered in seven low-income communities of color to improve asthma management and to build capacity for sustainability by developing active venues to inform, advocate, exchange information, and take action to make substantive changes.

Although grantees were required to employ a community coalition model, each coalition determined key strategies and implementation methods that aligned with community culture, practices, and resources (Clark et al., 2010). Because AAA coalitions recognized the influence of social determinants, each coalition incorporated a multilevel approach in its change strategies to influence both individual and systems changes (Clark et al., 2010). The seven coalitions achieved eighty-nine policy and system changes, ranging from changes in inter- and intra-institutional practice to new statewide legislation, as well as better health outcomes, such as reduced symptoms and improved health care utilization (AAA, 2011).

Community-Based Participatory Research (CBPR)

In the past two decades, community-based participatory research (CBPR), and complementary community-engaged research, practice-based research networks (PBRNs), tribally driven research, and other collaborative research networks have become recognized as instrumental to the reduction of health disparities, through building community capacity, diversifying the research workforce, recognizing the importance of cultural and implementation contexts within diverse communities, and increasing the external validity of research findings. Falling on the

end of the continuum of shared leadership or community-driven research, CBPR has a history of supporting bidirectional learning, allowing researchers to combine scientific knowledge with community expertise in the cultural and social contexts of the health issue and potential solutions that may work locally (Andrews et al., 2012). With engaged and equitable partnerships, CBPR has contributed to decreasing local health inequities and building capacity for social change (Cargo & Mercer, 2008; Israel et al., 2012; Minkler et al., 2008).

As with coalition evaluation, CBPR evaluation has been evolving from the publication of partnership processes to reporting on multiple intermediate systems change outcomes. These include often hard-won new health policies, sustainable and culturally centered community programs, and increased research and other community capacities, as well as evidence of improved health outcomes. (Evaluation is discussed further later in this chapter; also see this book's web resources.)

One example is the faith-based Bronx Health REACH partnership, a collaboration of the Institute for Family Health, black and Latino churches, and community-based organizations, among other groups. The partnership has braided its CDC, NIH, and other funding sources to tackle social determinants of health from a community-building, community organization, and CBPR perspective (Bronx Health Reach, 2010–2015). With an early focus on capacity building, it has adopted the community-building strategy of identifying pastors and lay church leaders who are willing to join the growing coalition (up to forty-seven churches from the original seven), which has the goal of creating multilevel interventions. These interventions include promoting healthier foods at church functions, sponsoring nutrition education and fitness activities, creating new health ministries with volunteer nurses and other health professionals in the congregation to sustain wellness efforts, and supporting pastors in integrating health messages into their sermons.

Bronx Health REACH has adopted community organization advocacy strategies to challenge New York City schools to adopt low-fat milk, a policy focus that has had them coming up against the dairy industry lobby. Partnership members have also confronted the two-tier medical system, a type of medical apartheid that results in unequal access to specialty care for their congregants who are either uninsured or on Medicaid on the one hand and the congregants with private insurance on the other hand, a disparity that disproportionately affects people of color. With NIH CBPR funding, they have adapted an evidence-based diabetes curriculum, using their culturally centered, faith-based model, to promote diabetes self-care and management. With commitment to CBPR principles, academic researchers involved in this project have located decision making within a community research committee that oversees Bronx Health REACH's faith-based initiative to codevelop and sustain the research methodology.

Application of Community Engagement: Immigrant Restaurant Workers in San Francisco's Chinatown

This extended application of community engagement showcases the models and principles of community organizing and building, coalition building, and community-based participatory research.

The cultural center of San Francisco's Chinese immigrant community, Chinatown is a dynamic neighborhood and international tourist attraction. For the roughly one-third of its residents who are employed in restaurants, however, Chinatown also means high rates of work-related illness and injury, including not only traditional problems such as cuts, burns, and on-the-job stress but also social and economic problems such as wage theft. A particular concern for low-wage immigrant workers, *wage theft* includes payment of wages below the minimum, delayed payment or denial of back wages, no paid sick leave or overtime pay, and confiscation of tip money (Bernhardt et al., 2009).

The Chinese Progressive Association (CPA) had been organizing around worker issues for over thirty years when it formed a CBPR partnership in 2007 to study restaurant worker health and safety in a coalition with the University of California, Berkeley, School of Public Health and its Labor Occupational Health Program (LOHP); the San Francisco Department of Public Health; and the University of California, San Francisco, Division of Occupational and Environmental Medicine. Six Chinese restaurant workers provided on-the-ground expertise to the research and were a focal point for CPA's efforts to develop leaders for its campaign to address working conditions.

Prior to the research, many hours of partnership meetings were held to reflect on the varying needs, strengths, and visions of different partners, the goals of the partnership, and the adaptations needed to better bridge the needs, strengths, visions, and goals (Chang et al., 2013). Worker partners engaged in an eight-week training using Freirean popular education activities and co-learning dialogue and critical reflection (Freire, 1970; Wallerstein & Auerbach, 2004), with follow-up weekly or biweekly sessions that underscored the importance of workers' insider perspectives, and taught participatory research skills, such as survey design and human subjects protection, as well as strategies to ensure workers' rights and health and safety. Concurrently with their CBPR participation, the worker partners were involved in ongoing CPA organizing activities.

The Chinatown immigrant restaurant workers study included focus groups with restaurant workers, a detailed survey of working conditions and health among 433 Chinatown restaurant workers, creation of an observational checklist that the health department used to collect data on working conditions in 106 of the 108 restaurants, and an evaluation of the partnership (Chang, Salvatore, Lee, Liu, & Minkler, 2012; Gaydos et al., 2011).

Worker partners and the CPA helped tailor both the survey and the checklist to be culturally and linguistically appropriate, with appropriate items of local relevance.

Study findings showed that 50 percent of the workers surveyed reported they did not receive the minimum wage, 17 percent were not paid on time, and 76 percent of those who worked more than forty hours a week were not paid overtime (CPA, 2010). The health department's checklist findings indicated multiple preventable hazards, including lack of posting of required minimum wage and other labor laws (65%) (Chang et al., 2012; CPA, 2010; Gaydos et al., 2011). Initial data analysis was conducted by two academic partners, and findings were quickly made available in accessible formats to worker partners, who participated in six data interpretation workshops. As they learned to speak the language of data analysis, they provided many insights into the data not originally apparent to other academic and agency partners (Chang et al., 2012; CPA, 2010).

A key step in translating the research into action was the CPA's drafting and launch of *Check, Please!*, a comprehensive report issued in three languages that summarized study findings and also discussed how these findings reflected broader trends for low-wage workers citywide and nationally. The report contained recommendations for action and featured a low-wage worker bill of rights, developed by the San Francisco Progressive Workers Alliance (PWA), a new coalition founded by CPA and other local worker organizations. The large press conference that launched *Check, Please!* drew close to two hundred people, including almost twenty reporters from mainstream and ethnic media and several city supervisors. Worker partners played a prominent role in this event, presenting research findings, and telling their own stories to put a human face on the data (the press conference may be viewed at www.youtube.com/watch?v=96dQzjKXFoE).

Following the launch event, the CPA, its worker partners, the PWA, and city supervisors worked together to develop the San Francisco Wage Theft Prevention Ordinance, which was unanimously passed and signed into law in 2011, making San Francisco the first U.S. municipality after Miami to have a wage theft ordinance. To ensure that the new legislation had teeth, several members of the Chinatown project then participated in an implementation task force that met monthly in city hall and saw some real enforcement victories. In February 2013, the city collected the largest wage theft settlement in the city's history (over $525,000) from a Chinatown pastry shop that had paid its employees just $4 an hour for working eleven hours a day, six days a week. Programs that could help incentivize the high-road employers, those who comply with labor laws and maintain healthy and safe working conditions, are also being explored, and the CPA and its partners continue to work on a citywide approach to address all low-wage worker communities (Gaydos et al., 2011).

Although community organizing and CBPR are heavily focused on engaging participants in studying and taking action to change their reality, an equally strong emphasis is placed on personal and collective transformation. In this case, worker partners reported less fear of engaging with new people and "talking to strangers," a greater sense of "courage" and confidence, owning issues and solutions through sharing of their own stories and experiences, and moving into the leadership of the CPA (Chang et al., 2012). In sum, the combination of Freirean popular education, community organizing, working in a coalition, and community-based participatory research increased workers' empowerment and community partners' organizational capacity and visibility, and helped secure passage and enforcement of anti–wage theft legislation. In this project, the participatory research activities were foundational to taking action for change, and the results were evident in the new policy legislation, enforcement of the new policy, and related sequelae. The project also is helping to improve the health of Chinese immigrant workers and of low-wage workers across the city.

Measurement and Evaluation Issues

A challenge for community engagement, community organization and community building, and community-based participatory research has been the difficulty of adequately addressing evaluation processes and outcomes, partially due to funding constraints, the lack of knowledge

about how to build meaningful evaluation into community engagement efforts, and the difficulty of determining appropriate outcomes. The continually evolving nature of community engagement, the complex and dynamic contexts in which it occurs, and the fact that these projects often seek change on multiple levels make many traditional evaluative approaches inadequate (Craig et al., 2008; Fetterman & Wandersman, 2005; Glasgow, 2013). The focus of standard evaluation approaches on distal health or social indicators may miss the shorter-term system impacts with which community engagement and organizing is concerned. Although many characteristics of successful community collaborations have been identified, such as shared vision, leadership, skills in building alliances across differences, and a focus on process and not merely tasks (Butterfoss, 2007; Chavez et al., 2010; Lasker & Weiss, 2003; Wolff, 2010), much remains to be assessed.

A growing number of new tools and resources are available for those interested in evaluating community organizing, capacity, coalitions, and engagement. Key among them are Foster and Louie's (2010) summary of tools for measuring community organizing, Butterfoss and Kegler's (2009) comprehensive community action model for understanding coalitions, Wolff's book *The Power of Collaborative Solutions* (2010), and the increasingly used, web-based Partnership Self-Assessment Tool (at www.nccmt.ca/uploads/registry/PSA%20Tool%20Questionnaire.pdf) (see also Lempa, Goodman, Rice, & Becker, 2008; Mattessich, Murray-Close, & Monsey, 2001; Zakocs & Edwards, 2006).

Both newer and time-tested approaches to measuring community empowerment and multilevel perceived control (Peterson et al., 2006; Wallerstein, 2006), civic engagement, and social capital are increasingly being seen as critical. Despite advances in measurement, however, there are limits to scales. For example, self-report measures of individuals cannot capture the full picture of organization- and community-level processes over time. Qualitative approaches are needed to enhance understanding of the context, dynamics of change, and outcomes such as transformed conditions, new policies, participation, and political voice.

Finally, CBPR instruments and measures offer promise for partnership evaluation (Israel et al., 2012), with the development of CBPR logic models (Hicks et al., 2012; Schulz, Israel, & Lantz, 2003) and with new CBPR metrics and measures from a current NIH mixed methods study of CBPR partnerships nationwide (Sandoval et al., 2012). A new community-engaged research infrastructure model within academic health centers presents potential categories for evaluation of university and community capacities (Eder, Carter-Edwards, Hurd, Rumala, & Wallerstein, 2013). Core constructs of partnership synergy (Jagosh et al., 2012; Khodyakov et al., 2011) and trust—measured with one of the earliest tools from the CDC's Prevention Research Centers (CDC, 2012; Lucero & Wallerstein, 2013)—are being seen as critical overarching elements of community engagement, social network formation, and partnership functioning.

Summary

The growing pivotal role of community engagement in health education, public health, social work, medicine, and community-engaged and participatory research reflects this approach's time-tested effectiveness and its fit with the most fundamental principles of these fields. Community engagement, as a whole, stresses strengths-based approaches, relevance or starting

"where the people are," and the importance of creating environments in which individuals and communities can become empowered as they increase their capacity to solve problems and demand their human rights to fair and equitable conditions that support health. While community engagement has shifted mostly to a collaborative, capacity-building approach, the social action traditions of community organizing are still critical in advocacy that challenges health-damaging policies and conditions that continue to create health inequities. Employing the full range of practices of honoring diversity and addressing inequities demands time and resources and also intellectual and emotional commitments that are strongly embedded within the key concepts and principles discussed in this chapter.

Whether engaged in pure community-driven organizing and engagement around issues the community identifies or borrowing skills from community organizing, community-building practice, and coalition partnerships, professionals and researchers can challenge themselves to examine their own cultural humility and dynamics of power in order to understand the complexities of working in partnership toward the goals of community ownership and empowerment. In sum, community engagement and organizing bring essential strategies to a wide variety of community and organizational settings and may hold particular relevance in the changing sociopolitical climate of the twenty-first century.

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