Principles of Community Engagement

CDC/ATSDR Committee on Community Engagement

Centers for Disease Control and Prevention
Public Health Practice Program Office
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For further information on community collaboration, visit the Public Health Practice Program Office Internet site at www.cdc.gov/phppo/ or contact Michael Hatcher at Mail Stop K39, 4770 Buford Highway, N.E., Atlanta, GA., 30341-3724 or email mth1@cdc.gov.

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About the Developers
The Centers for Disease Control and Prevention is the Nation's prevention agency. Its mission is to promote health and quality of life by preventing and controlling disease, injury, and disability.

The Agency for Toxic Substances and Disease Registry is a federal public health agency. Its mission is to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment.

The Academy for Educational Development is an independent, nonprofit organization addressing health and human development needs through education, communication, and technical assistance.

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Foreword

Increasingly, community involvement and collaborations have become the foundation of public health action. The Centers for Disease Control and Prevention (CDC) has seen the need to broaden the understanding of the key principles of community engagement, and is pleased to offer *Principles of Community Engagement* to public health professionals and community leaders interested in engaging the community in health decision-making and action. This document represents the first time that the relevant theory and practical experience of community engagement has been synthesized and presented as practical principles, or guidelines, for this important work.

Principles of Community Engagement contains definitions of key concepts and insights from the literature that support and influence the activities of community engagement. The principles, a set of nine fundamental guiding ideas, form the core of the document and hold true for efforts across public health disciplines regardless of the initiating organizations. A series of case examples, taken from real-life experiences, link these principles to the major components of the community engagement process.

You can use this document to improve communication, promote a common understanding, and strengthen community partnerships to fulfill shared public health goals. We hope you will find *Principles of Community Engagement* useful in your role as leaders in addressing today's critical health issues.

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Executive Summary

Community involvement and collaborations are cornerstones of public health action. In recent years, a number of programs, such as PATCH, APEX/PH, and Healthy Cities, have guided community mobilization activities. However, there remains a need to broaden our understanding of the key principles that underlie successful community engagement in public health.

As a result of this, the Centers for Disease Control and Prevention (CDC) established the Committee for Community Engagement in October 1995. The Committee was composed of representatives from across CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). It considered a growing body of literature reflecting relevant concepts and the practical experiences of those involved in engaging individuals and organizations in communities across the country. From these foundations the Committee synthesized a list of key Community Engagement Principles. These Principles form the core of *Principles of Community Engagement.* They hold true for community engagement activities across public health disciplines and apply regardless of the initiating organizations. They are the practical guidelines upon which all engagement efforts should be based.

Principles of Community Engagement provides public health professionals and community leaders with a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention. The material provided here can help public health professionals and community leaders improve communication, promote common understanding, and strengthen coordination, collaboration, and partnership efforts among themselves and community members and institutions. This book is also designed to help CDC programs and their partners guide community involvement in activities that affect or change health-related behaviors, including needs and asset assessment, planning, resource allocation, advocacy, outreach, program development, implementation, and evaluation.

It should be noted that this document was intentionally prepared for public health professionals and community leaders within organizations, rather than a more grass-roots audience. Therefore, those initiating the engagement effort *may* be outside the community they are trying to engage. Individuals involved in implementing engagement activities need to recognize their own role in the process and be responsive to the needs of the targeted community, as defined by that community. A community engagement process is more likely to be successful when true equality of community leadership is intended and applied, as opposed to an authoritative or top-down approach.

Community engagement is 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. Engagement principles can be used by people in a range of roles, from the chief executive of an organization or program funder who needs to know how to support community engagement, to the frontline health professional or community leader who needs hands-on, practical information on how to mobilize members of a community.

In practice, community engagement is a blend of science and art. The science comes from sociology, political science, cultural anthropology, organizational development, psychology, social work, and other disciplines with organizing concepts drawn from the literature on community participation, community mobilization, constituency building, community psychology, cultural influences, and other sources. The art comes from the understanding, skill, and sensitivity that is used to apply and adapt the science in ways that fit the community and the purposes of specific engagement efforts. The results of these efforts may be defined differently and encompass a broad range of possibilities (e.g., coalitions, partnerships, collaborations), but they all fall under the general rubric of community engagement and are treated similarly in this document.

Organization Of *Principles of Community Engagement*

The book is divided into three parts. Part 1 defines concepts of community and community engagement, and looks at why these are important in decision-making and action for health promotion, health protection, and disease prevention. It draws on organizing concepts found in the literature on community organization and development and on community participation. Part 2 summarizes the key principles of community engagement as derived from the literature and from practice, and as developed by the CDC/ATSDR Committee for Community Engagement. Part 3 links these principles to different aspects of the community engagement process. This linkage is illustrated through eight case examples showing how these approaches to engaging the community around specific health issues reflect the principles. Finally, an Appendix offers an extensive bibliography of available references to help readers learn more about the principles and concepts relevant to their communities. It includes all the references cited in the book as well as additional sources of information.

This document is a guide for understanding the principles of community engagement needed for developing and implementing a plan of action involving communities. Community processes can be difficult and labor intensive. They require dedicated resources — time, money, and people — to help ensure their success. While the case examples in this document highlight community engagement successes, failures do exist. We hope that thoughtful consideration of the community engagement principles, as well as the discussions that amplify them and the case examples that illustrate them, will help public health professionals and communities form partnerships that will lead to positive action on the pressing health issues facing us today, and ultimately, to improved health for the men, women, and children who live in our communities.

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Community Engagement: Definitions and Organizing Concepts from the Literature

During the past two decades, researchers have provided evidence to support the notion that the social environment in which people live, as well as their lifestyles and behaviors, can influence the incidence of illness within a population (IOM, 1988). They have also demonstrated that a population can achieve long-term health improvements when people become involved in their community and work together to effect change (Hanson, 1988-89).

In light of these developments, members of the disease prevention and health promotion communities have expanded their efforts to create positive environments and strong community action, and to use public policy in new ways that support community collaboration (WHO et al., 1986; Hanson, 1988-89). This thinking about public health, an outgrowth of the social change movements of earlier decades and more recently re-emerging as a dominant notion, stresses the importance of engaging the community in health decision-making and improving community participation in health promotion, health protection, and disease prevention efforts (Fawcett et al., 1993).

As a result of this renewed emphasis in public health efforts, health professionals and community leaders can envision many new opportunities to engage people. For example, the use of community collaborations to prevent violence, rather than relying solely on a law enforcement approach, is a newer strategy gaining widespread acceptance. At the same time, though, those working in this field have to confront a number of pragmatic issues. One is how to integrate this vision of community engagement into their organization's daily efforts. Moreover, the health professional, community organizer, or volunteer who sees promise in addressing the social environment as a means of promoting health may find it necessary to convince others of the usefulness of a particular community-level approach. This section of *Principles of Community Engagement* provides a place to turn for preliminary answers and useful arguments. It briefly discusses the meaning of community and some of the concepts that underlie our understanding of it. While not meant to be inclusive of all the available and relevant science, this section provides an overview of some of the critical organizing concepts from the social science literature that address community and community engagement.

The Concept of Community

The first step in considering the meaning of community is to understand that, fundamentally, it is a fluid concept. What one person calls a community may not match another person's definition. However, those interested in working with a community must first have a clear picture of the entity they are trying to address. Understanding the dimensions of the concept of community will enable those initiating engagement processes to better target their efforts and work with community leaders and members in developing appropriate engagement strategies.

How, then, can communities be defined? We can answer this question from two viewpoints — a broader sociological or systems perspective as well as a more personal, individual perspective. In either case, central to the definition of a community is a sense of "who is included and who is excluded from membership" (IOM, 1995). A person may be a member of a community by choice, as with voluntary associations, or by virtue of their innate personal characteristics, such as age, gender, race, or ethnicity (IOM, 1995). As a result, individuals may belong to multiple communities at any one time. When initiating community engagement efforts, one must be aware of these complex associations in deciding which individuals to work with in the targeted community.

From a sociological perspective, the notion of community refers to a group of people united by at least one common characteristic. Such characteristics could include geography, shared interests, values, experiences, or traditions. John McKnight, a sociologist, once said that if one were to go to a sociology department in search of a single, simple definition of the word community, one would "...never leave. To some people it's a feeling, to

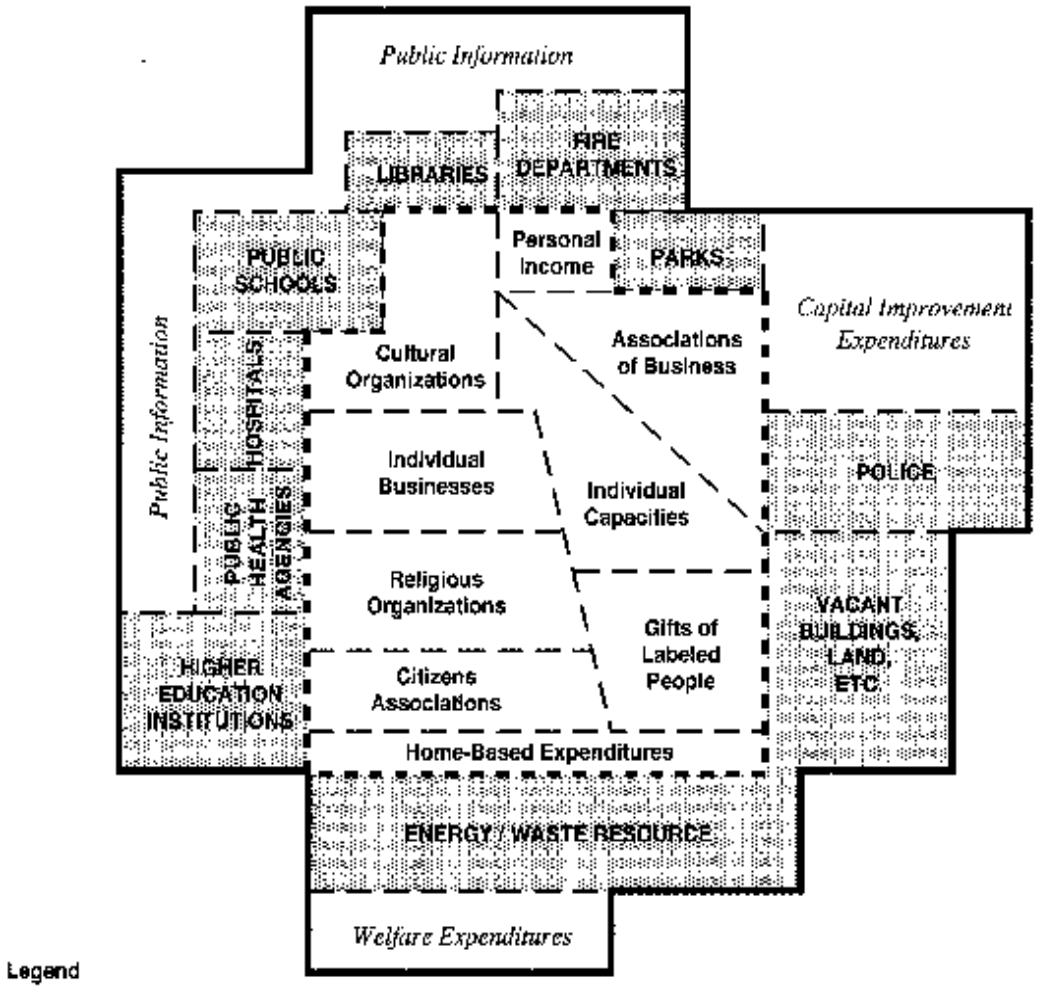
some people it’s relationships, to some people it’s a place, to some people it’s an institution" (CBC, 1994).

Communities may be viewed as systems composed of individual members and sectors that have a variety of distinct characteristics and interrelationships (Thompson et al., 1990). These sectors are populated by groups of individuals who represent specialized functions, activities, or interests within a community system. Each sector operates within specific boundaries to meet the needs of its members and those the sector is designed to benefit. For example, schools focus on student education, the transportation sector focuses on moving people and products, economic entities focus on enterprise and employment, faith organizations focus on the spiritual and physical well-being of people, and health care agencies focus on prevention and treatment of diseases and injuries. In reality, these sectors are a few of the many elements that comprise the overall community system.

A community can be viewed as a living organism or well-oiled machine. For the community to be successful, each sector has its role and failure to perform that role in relationship to the whole organism or machine will diminish success. In a systems view, healthy communities are those that have well-integrated, interdependent sectors that share responsibility to resolve problems and enhance the well-being of the community. It is increasingly recognized that to successfully address a community’s complex problems and quality of life issues, it is necessary to promote better integration, collaboration, and coordination of resources from these multiple community sectors.

One useful way to describe the community and its sectors is through a technique known as mapping (Kretzmann et al. 1993). As shown in the following diagram, someone interested in describing the bounds of a community can map it by identifying primary, secondary, and potential building blocks, or human and material resources. Each of these resources has assets that can be identified, mobilized, and used to address issues of concern and bring about change.

Neighborhood Assets Map



McKnight JL, Kretzmann J. *Mapping community capacity*. Evanston (IL): Center for Urban affairs and Policy Research, Northwestern University; 1990

Again, from the systems perspective, another way to understand and describe a community might involve exploring factors related to:

- People (socioeconomics and demographics, health status and risk profiles, cultural and ethnic characteristics)

- Location (geographic boundaries)

- Connectors (shared values, interests, motivating forces)

- Power relationships (communication patterns, formal and informal lines of authority and influence, stake holder relationships, resource flows)

(Adapted from VHA, 1993).

Similarly, we can define the community from a broader sociological perspective by describing the social and political networks that link individuals and community organizations and leaders. Understanding the nature and boundaries of these networks is critical to planning engagement efforts. For example, tracing individuals' social ties may help those who are initiating a community engagement effort to identify leaders within a community, understand community patterns, identify high risk groups within the community, and strengthen networks within the community (Minkler, 1997).

Beyond the collective definitions of community that researchers and organizers can apply, an individual also has her or his own sense of community membership. The presence or absence of a sense of membership in a community may vary over time and is likely to influence participation in community activities. This variation is affected by a number of factors. For example, persons at one time may feel an emotional, cultural, or experiential tie to one community; at another time, they might believe they have a contribution to make within a different group. At yet another time, they may see membership in a third distinct community as a way to meet their own individual needs (Chavis et al., 1990). Of course, they may also have this sense of belonging to more than one community at the same time. Before beginning an engagement effort, it is important to understand that all these potential variations and perspectives may exist and influence the work within a given community.

Concepts of Community Engagement

The CDC/ATSDR Committee for Community Engagement developed a working definition of community engagement. Loosely defined, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices (Fawcett et al., 1995).

In practice, community engagement is a blend of social science and art. The science comes from sociology, political science, cultural anthropology, organizational development, psychology, social work, and other disciplines with organizing concepts drawn from the literature on community participation, community mobilization, constituency building, community psychology, cultural influences, and other sources. Several of these concepts from the social science literature are presented here. The equally important artistic element necessary to the process, however, involves using understanding, skill, and sensitivity to apply and adapt the science in ways that fit the community and purposes of specific engagement efforts.

Insights from the Literature

Studies of participation in voluntary and community organizations have allowed social scientists and other researchers to develop organizing concepts about communities and the ways in which they are mobilized (Florin et al., 1990; Fawcett et al., 1995; Hanson, 1988-89; Thompson et al., 1990). Findings in the literature have helped to shed light on why community engagement is useful and how we can engage people to most effectively address public health issues. What follows are brief descriptions of some of the organizing concepts found in the literature that guide approaches to successful community engagement. Additional resources on these and other

concepts not included here may be found in the Bibliography.

Social Ecology

Social ecological theories provide insight into elements of individuals' lives that contribute to health promotion. Such theories seek to describe the concept of community in terms of a "dynamic interplay among individuals, groups, and their social and physical environments" (Stokols, 1996, p**.** 286). Researchers in this area help to integrate approaches to disease prevention and health promotion (which focus on modifying individual health behaviors) with environmental approaches (which focus on the physical and social environment). From the social ecology perspective, "the potential to change individual risk behavior is considered within the social and cultural context in which it occurs. Interventions that are informed by this perspective are directed largely at social factors, such as community norms and the structure of community services including their comprehensiveness, coordination, and linkages, in addition to individual motivations and attitudes." (Goodman et al., 1996, p. 34).

Social ecology theory as it informs health promotion suggests that community engagement efforts need to be focused at multiple levels — (1) individuals; (2) social network and support systems; (3) the range of organizations that serve and influence individuals and the rules and regulations that these organizations apply; (4) the community, including relationships among organizations, institutions, and informal networks; and (5) "public policy, regulations, ordinances and laws at the state and national levels" (Goodman et al., 1996, p. 35).

Several core concepts summarize the contributions of social ecology theories to community engagement efforts (Stokols, 1996, p. 285-286):

- Health status, emotional well-being, and social cohesion are influenced by the physical, social, and cultural dimensions of the individual's or community's environment and personal attributes (e.g., behavior patterns, psychological dispositions, genetics).

- The same environment may have different effects on an individual's health depending on a variety of factors, including perceptions of ability to control the environment and financial resources.

- Individuals and groups operate in multiple environments (e.g., workplace, neighborhood, larger geographic communities) that "spill over" and influence each other.

- There are personal and environmental "leverage points" that exert vital influences on health and well-being.

Cultural Influences

The literature on cultural influences suggests that health behaviors are influenced directly by elements of one's culture. As a result, social norms and other elements of community culture provide a potential tool for disease prevention and health promotion. Culture involves "the integrated pattern of human knowledge, belief, behavior, and material traits characteristic of a social group" (Braithwaite et al., 1994, p.409). Another way to understand this concept is to think of culture as the "luggage" we always carry with us — "the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals . . . that we have learned from our families" (Spector, 1985, p. 60). Cultural identity influences "the group's design for living, the shared set of socially transmitted perceptions about the nature of the physical, social, and spiritual world, particularly as it relates to achieving life's goals" (Airhihenbuwa, 1995, p. 5). Therefore, those who wish to work with community members should carefully examine the differences and similarities in cultural perceptions, so that engagement activities are appropriate for that particular cultural context. This appropriateness, often referred to as cultural sensitivity, means that

programs are developed "in ways that are consistent with a people's and community's cultural framework" (Airhihenbuwa, 1995, p. 7).

An individual's culture influences his or her attitude toward various health issues, including perceptions of what is and is not a health problem, methods of disease prevention, treatments for illness, and use of health providers. As Spector (1985, p. 59) notes: "We learn from our own cultural and ethnic backgrounds *how* to be healthy, *how* to recognize illness, and *how* to be ill . . . meanings attached to the notions of health and illness are related to basic, culture-bound values by which we define a given experience and perceptions." Individuals initiating community engagement activities should understand belief systems held by community members, especially if they are different from their own. Cultural experiences also can influence how individuals and groups relate to each other and to people and institutions of other cultures. Efforts to address these elements of a community could concentrate on affecting the landscape of information and ideas in which that community operates.

Community Participation

Concepts concerning community participation offer one set of explanations as to why the process of community engagement might be useful in addressing the physical, interpersonal, and cultural aspects of individuals' environments. The real value of participation stems from the finding that mobilizing the entire community, rather than engaging people on an individualized basis or not engaging them at all, leads to more effective results (Braithwaite et al., 1994). Simply stated, change "... is more likely to be successful and permanent when the people it affects are involved in initiating and promoting it" (Thompson et al, 1990, p. 46). In other words, a crucial element of community engagement is participation by the individuals, community-based organizations, and institutions that will be affected by the effort.

This participation is "a major method for improving the quality of the physical environment, enhancing services, preventing crime, and improving social conditions" (Chavis et al., 1990, p.56). There is evidence that participation can lead to improvements in neighborhood and community and stronger interpersonal relationships and social fabric (Florin et al., 1990). Robert Putnam notes that social scientists have recently "...unearthed a wide range of empirical evidence that the quality of public life and the performance of social institutions...are...powerfully influenced by norms and networks of civic engagement." Moreover, "researchers in...education, urban poverty,...and even health have discovered that successful outcomes are more likely in civically engaged communities" (Putnam, 1995, p.66). For example, Steckler's CODAPT model, for "Community Ownership through Diagnosis, Participatory Planning, Evaluation, and Training (for Institutionalization)," suggests that when community participation is strong throughout a program's development and implementation, long-term program viability, i.e., institutionalization, is more likely assured (Goodman et al., 1987-88).

The community participation literature suggests that:

- People who interact socially with neighbors are more likely to know about and join voluntary organizations.

- A sense of community may increase an individual's feeling of control over the environment, and increases participation in the community and voluntary organizations.

- Perceptions of problems in the environment can motivate individuals (and organizations) to act to improve the community (Chavis et al., 1990).

"When people share a strong sense of community they are motivated and empowered to change problems they face, and are better able to mediate the negative effects over things which they have no control," Chavis et al., (1990, p. 73) write. Moreover, "a sense of community is the glue that can hold together a community development effort" (Chavis et al., 1990, p. 73-74). This concept suggests that programs that "...foster membership, increase influence, meet needs, and develop a shared emotional connection among community

members" (Chavis et al., 1990, p. 73) can serve as catalysts for change and for engaging individuals and the community in health decision-making and action.

Community Empowerment

The literature suggests that a critical element of community engagement relates to empowerment — mobilizing and organizing individuals, grass-roots and community-based organizations, and institutions, and enabling them to take action, influence, and make decisions on critical issues. It is important to note, however, that no external entity should assume that it can bestow on a community the power to act in its own self-interest. Rather, those working to engage the community can provide important tools and resources so that community members can act to gain mastery over their lives.

Empowerment takes place at three levels: the (1) individual, (2) organizational or group, and (3) community levels (Rich et al., 1995; Fawcett et al., 1995). Empowerment at one level can influence empowerment at the other levels (Fawcett et al., 1995). At the individual level, it is generally referred to as psychological empowerment (McMillan et al., 1995; Rich et al., 1995). Individual level empowerment can be described along three dimensions: (1) intra-personal — an individual's perceived personal capacity to influence social and political systems; (2) interactional — knowledge and skills to master the systems; and (3) behavioral — actions that influence the systems (Rich et al., 1995). This concept of psychological empowerment has been found to relate to an individual's participation in organizations, the benefits of participation, organizational climate, and the sense of community or perceived severity of problem.

At the group or organizational level, the literature distinguishes between: (1) empowering organizations, which "...facilitate confidence and competencies of individuals;" and (2) empowered organizations, which influence their environment (Rich et al., 1995). The degree to which an organization is empowering for its members may be dependent upon the benefits members receive and organizational climate as well as the levels of commitment and sense of community among members (McMillan et al., 1995).

Community level empowerment (i.e., the capacity of communities to respond effectively to collective problems) occurs when both individuals and institutions have sufficient power to achieve substantially satisfactory outcomes (Rich et al., 1995). Individuals and their organizations gain power and influence by having information about problems and "an open process of accumulating and evaluating evidence and information" (Rich et al., 1995, p. 669). Empowerment involves "the ability to reach decisions that solve problems or produce desired outcomes," requiring that citizens and formal institutions work together to reach decisions (Rich et al., 1995).

Capacity Building

Another set of organizing concepts that can help guide approaches to effective engagement involves the process of capacity building. In essence, the literature on capacity building states that before individuals and organizations can gain control and influence and become players and partners in community health decision-making and action, they may need resources, knowledge, and skills above and beyond those they already bring to a particular problem (Fawcett et al., 1995). Participation in community engagement efforts can offer people the possibility of developing these skills.

The kind and intensity of capacity building that may be needed to sustain community engagement efforts is not entirely known; too often, community leaders can be caught up in "selling" the engagement effort without an accurate idea of the resources needed to actually support it over the long term (Florin et al., 1993). For example, people and organizations in the community might need technical assistance and training related to developing an organization, securing resources, organizing constituencies to work for change, participating in partnerships and coalitions, conflict resolution, and other technical knowledge necessary to address issues of concern to the community.

Coalitions

Engaging the community will very often involve building coalitions of diverse organizations. A community coalition can be defined as "a formal alliance of organizations, groups, and agencies that have come together to work for a common goal" (Florin et al., 1993, p. 417). Coalitions are usually characterized as "formal, multi-purpose, and long-term alliances" that "fulfill planning, coordinating and advocacy functions for their communities" (Butterfoss et al., 1993, p. 316, 318). They can be helpful in a number of ways, including maximizing the influence of individuals and organizations, exploiting new resources, and reducing duplication of effort. While the literature reveals that coalitions have not been systematically studied and contains little data to support their effectiveness, funding sources have been giving serious commitment to developing coalitions as an intervention to address health issues (Butterfoss et al., 1993).

The concept of coalition has its roots in political science. In parliamentary democracies, for example, a coalition government is formed by two or more parties when no single party has a sufficient mandate to represent the majority. In addition, in almost all kinds of governments, informal coalitions exist among factions that share general or specific policy or legislative objectives. The types of coalitions that might be necessary for engagement efforts can be viewed the same way. The experience of political theorists suggests that:

- Coalitions require a perception of interdependence; each party must believe it needs help to reach its goals.

- There must be sufficient common ground and a clearly articulated mission or purpose so the parties can agree over time on a set of policies and strategies.

- At the same time, coalition members typically have "primary" goals and perspectives that are distinct, if not conflicting; they agree on some issues but disagree on others.

- Coalitions require continuous and often delicate negotiation among participants.

- The distribution of power and benefits among coalition members is a major focus of ongoing concern; each member needs to believe that over time, he or she is receiving benefits that are comparable to their contributions (see discussion on *Benefits and Costs* below). (AED, 1993)

Benefits and Costs

A critical set of organizing concepts involves analysis of the benefits and costs of community engagement. The literature suggests that "participants will invest their energy in an organization only if the expected benefits outweigh the costs that are entailed" (Butterfoss et al., 1993, p. 322). It appears that an individual's desire to join and continue a commitment to an engagement effort depends more on this benefit-cost ratio than on his or her demographic characteristics (Wandersman et al., 1987). Potential benefits include: networking opportunities, access to information and resources, personal recognition, skill enhancement, and a sense of contribution and helpfulness in solving community problems. Costs can run the gamut from the contribution of time required, to lack of skills or resources needed for participation, to basic burn out. By identifying the specific benefits and barriers to participation in the engagement effort, community leaders can put the appropriate incentives in place.

The social exchange perspective investigates the benefits and costs of participation to help explain who participates and why. The literature has long discussed health-related organizations as being involved in an "exchange system" whereby they voluntarily share resources to meet their respective goals or objectives (Levine et al., 1961). Similarly, social exchange occurs among community members, organizations, and others to overcome potential costs in an engagement effort — "a social exchange takes place in organizations such that participants will invest their energy into the organization only if they expect to receive some benefits" (Wandersman et al., 1987, p. 538).

Community Organization

The community organization literature provides insight on the kinds of engagement activities that may prove useful. This and related concepts offer a path to engagement through a "process by which community groups are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching goals they have set" (Minkler, 1990, p. 257). Organizing activities are a way of activating the community to encourage or support social and behavioral change (Bracht et al., 1990). This approach to bringing about change at the community level is based on principles of empowerment, community competence, active participation and "starting where the people are" (Minkler, 1990, p. 270).

Labonte and Robertson support the particular importance of "starting where the people are" by stating that "if we fail to start with what is close to people's hearts by imposing our notions of health concerns over theirs, we risk several disabling effects..." (Labonte et al., 1996, p. 441). These include: being irrelevant to the community, exacerbating the community's sense of powerlessness, further complicating individuals' lives, and possibly channeling local activism away from broader challenges and into individual-level changes.

The community organization approach also reflects findings that individuals and communities: (1) must feel or see a need to change or learn, and (2) are more likely to change attitudes and practices when they are involved in group learning and decision-making (Minkler, 1990). An important element of community organizing is helping communities look at root causes of problems while at the same time selecting issues that are "winnable, simple, and specific," can unite members of the group, involve them in achieving a solution, and help build the community or organization (Minkler, 1990).

Community organizing can be an empowering process for individuals, organizations, and communities. At the individual level, community organizing activities provide individuals with the chance to feel an increased sense of control and self confidence and to improve their coping capacities (Minkler, 1990). These have been shown to have physical health benefits. Organizing activities also strengthen the capacity of communities to respond effectively to collective problems. Individuals, organizations, and communities can be empowered by having information about problems and "an open process of accumulating and evaluating evidence and information" (Rich et al., 1995, p. 669).

Stages of Innovation

The concept of stages of innovation can be useful when dealing with the potential differences that might exist within a community as it changes over time. All individuals within a community are not necessarily at the same stage of readiness to change behaviors. This is an important notion to understand before and during a community engagement effort. Rogers offered one of the earliest formulations of this idea with his 1962 work, *Diffusion of Innovations.* In this book he states that all individuals do not adopt innovations at the same rate or with the same willingness. Stages of innovation, in general, can help implementors of engagement efforts to match strategies to the readiness of a community to adopt them. In applying these concepts to community development, for example, desired outcomes are predicated upon the community working through a number of phases, including raising awareness of the severity of a health problem, transforming awareness into concern for the problem, establishing a community-wide intervention initiative, and developing the necessary infrastructure so that service provision remains extensive and constant in reaching residents.

General Conclusions about the Power and Userfulness of Community Engagement

There is a consensus in the literature that engaging and supporting the empowerment of the community for community health decision-making and action is a critical element in health promotion, health protection, and disease prevention. The impact of programs that target individual behavior change is often transient and diluted unless efforts are also undertaken to bring about systematic change at multiple levels of society (Braithwaite et al., 1994).

Scholars have described several trigger activities that might begin the community engagement process. Some of these trigger activities are tied to legislative or program mandates, while others involve special initiatives, such as those of public health departments, grant makers, health service providers, or existing community groups and coalitions. Once triggered, the community engagement process itself can take many forms. It can range from cooperation, where relationships are informal and where there is not necessarily a commonly-defined structure, to collaboration, or partnerships where previously separated groups are brought together with full commitment to a common mission (Mattessich et al., 1992).

The organizational concepts from the literature discussed in this section of the document lead to a number of general conclusions about what lies at the heart of successful community engagement efforts. These conclusions, which follow here, provide a useful segue to the community engagement principles outlined in Part 2.

• Community engagement efforts should address multiple levels of the social environment, rather than only individual behaviors, to bring about desired changes.

• Health behaviors are influenced by culture. To ensure that engagement efforts are culturally and linguistically appropriate, they must be developed from a knowledge and respect for the targeted community's culture.

• People participate when they feel a sense of community, see their involvement and the issues as relevant and worth their time, and view the process and organizational climate of participation as open and supportive of their right to have a voice in the process.

• While it cannot be externally imposed on a community, a sense of empowerment — the ability to take action, influence, and make decisions on critical issues — is crucial to successful engagement efforts.

• Community mobilization and self-determination frequently need nurturing. Before individuals and organizations can gain control and influence and become players and partners in community health decision-making and action, they may need additional knowledge, skills, and resources.

• Coalitions, when adequately supported, can be useful vehicles for mobilizing and using community assets for health decision-making and action.

• Participation is influenced by whether community members believe that the benefits of participation outweigh the costs. Community leaders can use their understanding of perceived costs to develop appropriate incentives for participation.

The following table, based on the social science literature and the above conclusions, offers a set of specific factors that can positively influence the success of community engagement efforts. Planners and organizers of these efforts may find it useful to keep the factors in mind as they work through the engagement process and apply the principles detailed in Part 2.

Factors Contributing to the Success of Community Engagement Efforts

Environmental
· History of collaboration or cooperation in the community
· Collaborating group (and agencies in group) seen as leader in community · Favorable political and social climate

Membership
· Mutual respect, understanding, and trust
· Appropriate cross-section of members
· Members see engagement in their self-interest — benefits of engagement as offsetting costs
· Ability to compromise

Process/Structure
· Members feel ownership — share stake in both process and outcome
· Every level in each organization in collaborating groups participates in decision-making
· Flexibility of collaborating group
· Clarity of roles and guidelines
· Ability to sustain itself in midst of changing conditions

Communication
· Open and frequent interaction, information, and discussion
· Informal and formal channels of communications

Purpose
· Goals clear and realistic to all partners
· Shared vision
· Unique to the effort (i.e., different at least in part from mission, goals or approach of member organizations)

Resources
· Sufficient funds
· Skilled convener

(Based on a review of the literature and excerpted from Mattessich and Monsey, 1992)

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For further information on community collaboration, visit the Public Health Practice Program Office Internet site at www.cdc.gov/phppo/ or contact Michael Hatcher at Mail Stop K39, 4770 Buford Highway, N.E., Atlanta, GA., 30341-3724 or email mth1@cdc.gov.

Principles of Community Engagement

In developing this document, the CDC/ATSDR Committee for Community Engagement drew on their knowledge of the literature and on practice experiences as well as the collective experience of their constituencies in the practice of community engagement. These practical experiences combined with the organizing concepts from the literature, as discussed in Part 1, suggested several underlying principles that can help guide community leaders in designing, implementing, and evaluating community engagement efforts. As many have learned, community processes can be difficult and labor intensive. They require dedicated resources to help ensure their success. CDC/ATSDR hopes that thoughtful consideration of these principles will help community leaders to form effective engagement partnerships.
Each principle covers a broad practice area of engagement, often addressing multiple issues, and is organized in three sections — items to consider before starting the engagement effort, what is necessary for engagement to occur, and what to consider for the engagement to be successful. The nine principles are numbered and discussed below.

BEFORE STARTING A COMMUNITY ENGAGEMENT EFFORT . . .

1. Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.

The implementors of the engagement process need to be able to communicate to the community why participation is worthwhile. Of course, as seen in the discussion under *Coalitions* and *Community Organization* in Part 1, simply being able to articulate that involvement is worthwhile does not guarantee participation. Those implementing the effort should be prepared for a variety of responses from the community. There may be many barriers to engagement and, as discussed in Part 1's *Benefits and Costs*, incentives should be established to help overcome these barriers. The processes for involvement and participation must be appropriate to meet the overall goals and objectives of the engagement.

The impetus for specific engagement efforts may vary. For example, legislation may make community involvement a condition of funding. Institutions or health professionals, on the other hand, may see community organizing and mobilization as part of their mission or profession. In other instances, outside pressures may demand that an entity be more responsive to a wide range of community concerns.

Community engagement goals also vary. For example, a community engagement effort could be focused on very specific health issues, such as HIV/AIDS, tuberculosis, substance abuse, immunizations, or cardiovascular disease. On the other hand, an effort might have a very broad focus, with either a direct or indirect impact on health improvement and disease prevention in the community. Examples of broad efforts are those that:

- are directed at overall community improvement, including economic and infrastructure development, which will indirectly contribute to health improvement and disease prevention, or

- ask community members to specify their health-related concerns, identify areas that need action, and become involved in planning, designing, implementing, and evaluating programs to promote and protect health and prevent disease.

The level at which these goals are focused has implications for managing and sustaining the engagement. A broader goal may enable community leaders to involve larger segments of the community, while a narrower focus may keep activities more directed and manageable.

Similarly, there are several dimensions to participation by the community. Leaders of community engagement efforts need to be clear about whether they: (1) are seeking data, information, advice, and feedback to help them design programs; or (2) are interested in partnering and sharing control with the community. This second kind of partnership includes being willing to address the issues that the community identifies as important — even if those are not the ones originally anticipated.

It is equally important to be clear about who is to be engaged — at least initially. Is it a geographic community and all of those who reside within its boundaries? Or, is it a specific racial/ethnic group, an income-specific population, or an age group, such as youth? Is it a specific set of institutions and groups, such as faith communities, schools, or the judicial system? Or, is it a combination? Answers to these questions will begin to provide the parameters for the engagement effort.

2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.

It is important to learn as much about the community as possible, through both qualitative and quantitative methods from as many sources as feasible. As discussed in Part 1, many of the organizing concepts found in the literature support this principle regarding community diagnosis. Social ecological theories, for example, emphasize the need to understand the larger physical and social environment, as well as individual health behaviors. An understanding of the community's perceived benefits and costs to participating can influence successful engagement. The concept of stages of innovation also highlights the need to diagnose where the community is in terms of readiness to adopt new strategies.

This understanding of the community will help leaders in the engagement effort to map community assets (see McKnight and Kretzmann's technique described in Part 1), develop a picture of how business is done, and identify the individuals and groups whose support is necessary. The information may also provide clues about who must be approached and involved in the initial stages of engagement.

Many communities are already involved in coalitions and partnerships around specific issues such as HIV/AIDS, substance abuse prevention, and community and economic development. It is important to consider how trying to engage or mobilize the community around new issues may affect these pre-existing efforts.

It is also helpful for those initiating the process to consider how the community perceives them (or their affiliations). Understanding these perceptions can help identify strengths that can be built upon and barriers that may need to be overcome.

FOR ENGAGEMENT TO OCCUR, IT IS NECESSARY TO . . .

3 . Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

Engagement is based on community support for whatever the process is trying to achieve. The insights from the literature on community participation and organization, as discussed in Part 1, illuminate this principle of community engagement. The literature suggests that positive change is more likely to occur when community

members are an integral part of a program's development and implementation. Potential participants need to see that respect for community members and opinion leaders is being fostered. For example, meeting with key community leaders and groups in their surroundings helps to build trust for a true partnership. Such meetings provide organizers of engagement activities with more information about the community, its concerns, and factors that will facilitate and constrain participation. Once a successful rapport is established, the meetings and exchanges with community members can snowball into an ongoing and substantive partnership.

When going into the community, some implementors find it most effective to reach out to the fullest possible range of formal and informal leaders and organizations. They try to work with all factions, expand the engagement table, and avoid becoming identified with one group. Alternatively, implementors of engagement efforts may find that identifying and working with key stakeholders is the most successful approach. Therefore, they engage with a smaller, perhaps more manageable, number of community members to achieve their mission. The range of individuals and groups contacted for an engagement effort depends in part on the issue at hand, the engagement strategy chosen, and whether the effort is mandated or voluntary.

It is essential for those engaging the community to adhere to the highest ethical standards. Past ethical failures have created distrust among some communities and have produced great challenges for current community organizers. If there is any potential for harm within the community through its involvement or endorsement of an intended action, the community must be educated to those risks so that an informed decision is possible. Failure to act ethically is not an option. Ethical action is the only hope for developing and maintaining the trust of communities.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.

Just because an institution or organization introduces itself *into* the community does not mean that it is automatically *of* the community. An organization is of the community when it is run by and controlled by individuals or groups who are members of the community. This dynamic can be quite complex — communities themselves may be composed of factions that contend for power and influence. It should be recognized that internal and external forces may be at play in any engagement effort. As Principle #6 below discusses, a diversity of ideas may be encountered and negotiated throughout the engagement process.

As strongly supported by the literature on community empowerment, issues, problems, and potential solutions should be defined by the community. Communities and individuals need to "own" the issues, name the problem, identify action areas, plan and implement action strategies, and evaluate outcomes.

People in a community are more likely to become involved if they identify with the issues being addressed and consider them important, and feel they have influence and can make a contribution. Participation will also be easier if people encounter few barriers to participation, find that the benefits of participating outweigh the costs (e.g., time, energy, dollars), and believe the participation process and related organizational climate are open and supportive.

FOR ENGAGEMENT TO SUCCEED . . .

5. Partnering with the community is necessary to create change and improve health.

The American Heritage Dictionary defines partnership as "a relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal." Many of the organizing concepts highlighted in Part 1, namely social ecology, community participation, and community organization, speak to the relationship between community partnerships and positive change. We know from discussions on empowerment that equity in these partnerships is more likely to lead to desired outcomes (see

Principle #4). The individuals and groups involved in a partnership must feel that they each have something to contribute and something to gain. Every party in such a relationship also holds important responsibility for the final outcome of an effort.

6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.

Diversity may be related to economic, educational, employment, and health status as well as to differences in cultures, language, age, mobility, literacy, and interests. Engaging these diverse populations will require the use of multiple engagement strategies.

Culture relates to traditions, values, and norms of a particular group of people. It may be rooted in family and heritage (e.g., the culture associated with ethnicity and religion), or in affinity groups (e.g., clubs and associations). We know from the literature on cultural influences that the processes, strategies, and techniques used to engage the community around health promotion, health protection, and disease prevention must be respectful of and designed to complement these traditions.

7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.

Community assets include the interests, skills, and experiences of individuals and local organizations. Individual and institutional resources such as facilities, materials, skills, and economic power all have the potential for being mobilized for community health decision-making and action. Community structures and members should be viewed as resources for change and action. The *Benefits and Costs* discussion in Part 1 highlights the need to make an exchange of resources available to ensure community participation. Of course, depending on the "trigger" for the engagement process (i.e., a funded mandate vs. a more grass-roots effort), resources are likely to be quite varied.

The literature involving *Capacity Building* and *Coalitions* stresses that engagement is more likely to be sustained when appropriately nurtured. Engaging the community around health decision-making and action may involve providing experts and resources to help communities develop the necessary capacities and infrastructure to analyze situations, make decisions, and take action. This assistance may involve training in leadership, facilitating meetings and discussions, and other skills-building activities.

8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.

Engaging the community is ultimately about community-driven action (see discussions under *Community Empowerment* and *Community Organization* in Part 1). While balancing with the need to create a manageable process, community action should include as many different elements of a community as possible in order to be sustained. The community engagement process is also a way to facilitate behavior change that is acceptable to the community. As a result, change will occur in relationships and in the way institutions and individuals demonstrate their capacity and strength to act on specific issues. Coalitions, networks, and new alliances are likely to emerge. Efforts will affect public and private programs, policies, and resource allocation. Those implementing engagement efforts must be prepared to anticipate and respond to these changes.

9. Community collaboration requires long-term commitment by the engaging organization and its partners.

Communities differ in their stage of development (see *Stages of Innovation* in Part 1). As discussed under Principle #7 and supported by the literature on *Coalitions* and *Capacity Building*, community participation and

mobilization frequently need nurturing over the long term. Building trust and helping communities develop the capacity and infrastructure for successful community action take time. Before individuals and organizations can gain influence and become players and partners in community health decision-making and action, they may need additional resources, knowledge, and skills. For example, people and organizations in the community might need long-term technical assistance and training related to developing an organization, securing resources, organizing constituencies to work for change, participating in partnerships and coalitions, resolving conflict, and other technical knowledge necessary to address issues of concern.

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Applying Principles to the Community Engagement Process

Introduction

Every organization in the health field has customers, clients, or constituents who influence how the work is accomplished and received. As a result, conducting and managing community engagement activities are ongoing and critical responsibilities of every organizational leader involved in health-related decision-making. The community engagement process means working with and through constituents to achieve common goals. The process demands that those implementing the engagement effort communicate with community leaders and members who have diverse backgrounds, values, priorities, and concerns. It is at this point that the principles and organizing concepts underlying community engagement come together with real-world activities.

Part 3 of *Principles of Community Engagement* illustrates the application of community engagement principles through examples of eight successful community collaborations and a discussion of the principles they illustrate. The case examples are brief descriptions of the project, based on the source materials listed, and their development did not involve extensive interviews with the individuals involved in the particular engagement effort. However, each of the case examples illustrates at least one principle; some embody many of them. They are presented in an effort to highlight ways in which the principles can be used in community engagement.

On pages the following pages, the principles are repeated and the eight case examples are listed. A matrix is then provided that shows the collaborations and the principles they embody. Part 3 closes with the case examples and a more detailed discussion of the community engagement principles, incorporating elements of the case examples.

Principles of Community Engagement

Before Starting a Community Engagement Effort . . .

1. Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.

2. Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.

For Engagement to Occur, It Is Necessary to . . .

3 . Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow to a community the power to act in its own self-interest.

For Engagement to Succeed . . .

5. Partnering with the community is necessary to create change and improve health.

6. All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.

7. Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.

8. An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.

9. Community collaboration requires long-term commitment by the engaging organization and its partners.

Successful Community Engagement Efforts

The following pages present eight examples of successful community engagement collaborations. They are:

• Identifying Community Leaders (Thurston County Public Health and Social Services Department and APEX/PH; Olympia, Washington)

• The Church as a "Natural" Partner in Health Promotion (The Jackson County Health Advisory Council; Jackson County, Florida)

• Community Self-Determination in Breast Cancer Research (National Breast Cancer Coalition; Philadelphia, Pennsylvania)

• A "Good Research Agreement": Preserving Community Culture and Self-Determination (The Mohawk Community of Akwesasne; Hogansburg, New York)

• National Cancer Institute: ASSISTing Change in Community Health (American Cancer Society Affiliates, State Health Departments, and Community-Based Coalitions; Detroit, Michigan)

• The Community Makes it a "Safe Night" for Public Health (City of Milwaukee Health Department and Milwaukee Violence Prevention Coalition; Milwaukee, Wisconsin)

• Community Care Network (The Hospital Research and Educational Trust, American Hospital Association, the Catholic Health Association of the United States, and the Voluntary Hospitals Association; Chicago, Illinois)

• Networks for Community Health (North Carolina Community-Based Public Health Initiative; Chapel Hill, North Carolina)

Case Example	Principle 1	Principle 2	Principle 3	Principle 4	Principle 5	Principle 6	Principle 7	Principle 8	Principle 9

Identifying Community Leaders (Thurston County Public Health and Social Services Department and APEX/PH)	–	–	–	–	–				
The Church as a "Natural" Partner in Health Promotion (Jackson County Health Advisory Council)		–	–		–	–	–		
Community Self-Determination in Breast Cancer Research (National Breast Cancer Coalition)			–	–			–		
A "Good Research Agreement": Preserving Community Culture and Self-Determination (Mohawk Community)			–	–		–		–	–
National Cancer Institute: ASSISTing Change in Community Health (ACS					–			–	–

Affiliates, State Health Departments, and Community-Based Coalitions)									
The Community Makes it a "Safe Night" for Public Health (City of Milwaukee Health Department and Milwaukee Violence Prevention Coalition)							–		–
Community Care Network (The Hospital Research and Educational Trust)	–	–	–	–	–				
Networks for Community Health (North Carolina Community-Based Public Health Initiative)			–	–	–	–	–		–

Note: The rationale for each _ is offered both within each case example abstract and in the narrative section that follows the case examples.

Identifying Community Leaders
Thurston County Public Health and Social Services Department and APEX/PH
Olympia, Washington

The Assessment Protocol for Excellence in Public Health (APEX/PH) is a process used by local health departments to examine and improve their ability to meet the health needs of their communities. APEX/PH consists of three stages: an organizational capacity assessment, a community process, and a final "completing the cycle" stage. The following is an example of how one public health agency responded to their APEX/PH-identified deficiencies in community assessment and planning. Their solution was to identify community

leaders whose input would enhance the credibility of their community health plans within the community. Consistent with community engagement Principles #1 - #5, this approach recognizes the need to establish relationships within the community and work with existing leadership to support the goals of a public health initiative.

During the initial stage of their APEX/PH project, the Thurston County Public Health and Social Services Department identified a need to strengthen their community health assessment and planning capabilities. This issue was addressed in the second stage of the process with the establishment of a County Community Health Task Force, whose members were selected through a modified "key informant" process. Key informants are individuals who represent important constituencies through their knowledge of or experience with the health issues being addressed. The agency convened a breakfast meeting with community leaders, and asked participants to provide the names of appropriate individuals to participate in the Task Force. In essence, participants were asked: "Whose name would you have to see on a health plan to believe it was valuable?" Task Force members were then selected from among the recurring names that appeared in the responses.

Before convening the Task Force, the agency collected comprehensive community data and published it in a book entitled, *Health Status of Thurston County*. Results from the data book, as well as the perceptions of the Task Force, were used to identify 15 health issues. The Task Force then used a variety of techniques, including some modified versions of those described in the APEX/PH workbook to set priorities among the 15 issues. However, the Task Force was uncomfortable with selecting the top three or five health issues and decided to pursue all of the issues that had been identified.

The Task Force divided into three subcommittees — clinical, environmental, and social — each of which developed plans to address specific issues within the 15. These subcommittees considered current efforts, additional efforts needed, and how to evaluate results. The clinical subcommittee focused on the problems of dental decay in children, immunization of preschool children, and overnutrition and obesity in school-age children. The environmental subcommittee addressed air quality, water quality, food safety, and preventable injury. The social subcommittee looked at issues of child abuse and domestic violence, and alcohol and drug misuse and dependence.

In May 1995, the Thurston County Community Health Task Force published *Strategies for a Healthy Future* detailing the health issues and the strategies devised to address each issue. The Task Force members recruited a wide range of organizations to lead the implementation of the strategies. An important outcome of this approach, according to one county official, was that "the community now feels a responsibility to make a difference. They're investing time and energy into moving toward implementation. It's not a health department work plan. It's a community health plan — owned and planned by the community — in which the health department participates."

Source:
Centra L, McDonald S. APEX in practice. In: *National Association of County and City Health Officials (NACCHO) Newsletter.* Washington (DC): National Association of County and City Health Officials; 1997 March.

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The Church as a "Natural" Partner in Health Promotion
The Jackson County Health Advisory Council
Jackson County, Florida

Bringing health promotion activities to members of the community often requires mobilizing the community's existing assets, both people and institutional resources, as described in Principle #7. Planned Approach to Community Health (PATCH) is a process developed by the Centers for Disease Control and Prevention (CDC) that is specifically geared toward planning and implementing community-based public health strategies. PATCH is founded on the principles of community support and participation in health promotion. Each element of PATCH is characterized by local leadership and decision-making. Instruments can be modified to appropriately reflect cultural diversity, as stressed in Principle #6. Through the use of PATCH, participants are able to learn more about different aspects of the community (Principle #2). In Jackson County, Florida, as in many parts of the country, public health agencies are turning to churches, which can be the most prominent social and cultural institutions in a community. This approach recognizes Principle #3, which asks organizers of community engagement to establish relationships and work with existing leadership structures. With their tradition of community leadership and service, churches are seen as "natural" partners in achieving public health goals. The initiative described below demonstrates how health-related programs have been organized and operated by churches with the support of public health agencies and educators. It also fulfills Principle #5 by demonstrating the value of creating true partnerships by integrating health promotion into the community's established structures.

African Americans in rural Jackson County, Florida, are at greater risk for a variety of health problems than are Whites in the county. This is indicated by higher death rates from heart disease, cancer and stroke, as well as a greater number of low birthweight babies and other health problems. Twenty-five percent of the county's residents are African Americans. Officials from county health and social service agencies and public health educators saw this disparity in health status as evidence that a targeted health promotion effort was needed. They joined with church leaders, many of whom had a track record of success in mobilizing the community, to formulate an initiative based on a culturally appropriate version of PATCH.

In Jackson County, the church was an obvious place to start for community health promotion. In addition to their significant presence (more than 80 Protestant churches) in the county, churches are influential social and cultural institutions within the African American community. The church is also seen as a community resource because of its role as a meeting place and focal point in many rural regions and because of its traditional role in serving the interests of the community.

One of the initial steps taken by Jackson County was to establish a Health Advisory Council, composed of 16 primarily African American Jackson County churches plus representatives of relevant agencies. Most of the participating church leaders were also leaders in numerous local community organizations. After undergoing a period of training and planning, the Council acquired the skills and resources necessary to encourage other local churches to design, implement, and evaluate their own health promotion programs.

Participating churches were selected according to the following criteria: (a) a minimum of 75 active church members; (b) commitment to the program by the church pastor; (c) willingness to establish a church health committee of at least 8 members; and (d) commitment to participate in training, including training in data collection. Each participating church established a health council responsible for planning a health promotion program. These individual programs were based on (a) the health needs of the individual church's membership and (b) broader health priorities as determined by the Health Advisory Council with technical support from agency staff.

The priorities identified by the Council were based on data from a community survey, the vital statistics for Jackson County, and data on health-related behaviors among Floridians in general. Based on these combined data, the Health Advisory Council determined that cardiovascular disease was a particular problem for non-whites in the county and this problem was related to poor nutritional practices, lack of exercise, smoking, stress,

obesity, and lack of medical attention. The Council recommended that these and other behaviors relating to heart problems should be the focus of the church-based efforts.

The Council organized workshops to provide church participants with basic cardiovascular and health information and to help them plan and operate church-based programs. Church leaders encouraged community members to participate in health promotion activities conducted at the churches and other community gathering places. Activities typically included blood pressure monitoring, direct health instruction, exercise programs, and special programs in various aspects of health. A core of church leaders and members fulfilled a variety of functions, from taking blood pressures to serving as peer facilitators. Program planners also emphasized the integration of health promotion activities with existing church events, for example, by scheduling an activity immediately after worship services.

To supplement and reinforce these activities, the Council placed in local libraries a variety of culturally-appropriate educational resources that focused on nutrition, exercise, and mental health. Resources included videotapes, training packets, games, manuals, and newsletters. The Council also disseminated information about health promotion through radio announcements, church bulletins, and monthly newsletters.

According to an assessment of the impact of the church-based program, it appeared that community awareness was raised with regard to health promotion, as indicated by the increases in program participants over the course of several years. Although dramatic effects were not demonstrated, the programs also appeared to produce improved nutritional behaviors of some people (e.g., decreases in consumption of fatty and high-sodium foods, and increases in consumption of healthful foods) and decreases in blood pressure rates among some high-risk individuals.

Sources:

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Sutherland M, Barber M, Harris G, Warner V, Cowart M, Menard A. Planning preventive health programming for rural blacks: developmental processes of a model PATCH program. *Wellness Perspectives: Research, Theory, and Practice* 1989;6(1):57-67.

Turner LW, Sutherland M, Harris GJ, Barber M. Cardiovascular health promotion in North Florida African-American churches. *Health Values* 1995;19(2):3-9.

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Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Community Health Promotion and Integrated Programs
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Community Self-Determination in Breast Cancer Research
National Breast Cancer Coalition
Philadelphia, Pennsylvania

The National Breast Cancer Coalition (NBCC) offers a model of community engagement in which members of the community become their own advocates to mobilize resources on behalf of a public health issue. Here, community is defined by a shared interest or experience, in this case being affected by breast cancer, rather than a particular demographic characteristic. At NBCC's foundation are a number of community-based support groups, which reflects the desire to establish relationships within the community (Principle #3). The coalition, very much in line with the concept of community self-determination (Principle #4), crafted new roles for women

with breast cancer in determining the directions of research in their disease. The coalition also took steps to provide members of their community with the capacity — the skills and knowledge — to participate in and contribute to the public health and policy processes (Principle #7).

The NBCC was formed in May 1991 by 100 community-based breast cancer support groups. Its goal was to overcome the nation's lack of progress in combating breast cancer, a leading cause of cancer death among women. The Coalition attributed the lack of progress in large part to the approaches taken by clinicians and researchers, specifically their emphasis on treatment rather than on prevention and diagnosis. Reversing this lack of progress became a focal point of the Coalition's activities.

One central strategy, established during the Coalition's first meeting, was to promote research on causes, treatments, and potential cures. Although all but a few at the meeting were non-scientists, the Coalition specifically wanted to see increased funding for research, expanded recruitment and training of scientists, and improved coordination among breast cancer research activities.

As its first major initiative, the Coalition launched a signature campaign called "Do the Right Thing," which produced 600,000 letters that the Coalition delivered to President Bush and Congress asking for increased breast cancer research. This and the Coalition's related efforts contributed to the decision for increased federal funding for breast cancer research. The Coalition wanted to do more than just add money to existing research. It wanted to change the research enterprise to make it more efficient, more effective, and more responsive to the needs of women with breast cancer.

One of the first priorities established by NBCC was to increase consumer involvement in every aspect of breast cancer research. Dr. Kay Dickersin, an assistant professor at the University of Maryland who was diagnosed with breast cancer a decade ago, describes the Coalition's rationale:

"We are the subjects of the research. Without us, the research could not take place. We are also the people to whom the research is applied once something is learned. So to leave us out of the research process other than to serve in research studies and to be the users of medical care, really makes no sense."

Dickersin believes a potential role exists for consumers in each step of the research process: in the initial decisions about planning and designing a research project, in the review of the study by institutional review boards and peer review groups, and on the ethical and administrative oversight committees for the study.

One of the most difficult barriers to consumer participation in the research design process is the difficulty in communication between scientists and consumers. Researchers are resistant to involving non-scientists in their projects, citing the lay person's lack of scientific training and a concern that input from consumers will bias the research. On the other side, consumers tend to be intimidated in scientific meetings and unwilling to assert their views.

To address this "disconnect" between research and the community, the NBCC has undertaken an initiative aimed at preparing consumers for participation in research. Called Project Leadership, Education, and Advocacy Development (Project LEAD), this is a 4-day course designed to increase the influence of breast cancer activists in scientific decision-making. The course includes a full day on basic science, which reviews DNA replication, transcription, translation, cell cycle, cell signaling, genetic linkage, and other issues. It also covers epidemiologic methods and statistics. Other activities include training in advocacy skills, including role-playing, to train women with breast cancer to express their point of view in the context of a scientific meeting.

Having consumers involved in research is good for both patients and researchers, observes Dickersin, who adds:

"Patients are telling about what the disease means to them and the outcomes that are important. This has a positive impact on research so that we are not just looking at it in terms of lab outcomes and survival, but other outcomes important to human beings. The strong partnership with the consumer groups has increased the validity and relevance of research as far as I am concerned."

Source:

Dickersin, K. Presentation at: Institute of Medicine, Committee to Identify Strategies to Raise the Profile of Substance Abuse and Alcoholism Research; 1996 March; Washington, DC.

A "Good Research Agreement": Preserving Community Culture and Self-Determination
The Mohawk Community of Akwesasne
Hogansburg, NY

Recognition of a community's cultural norms (Principle #6) and the need for community self-determination (Principle #4) are essential for gaining acceptance of a project initiated by an outside entity. Presented below is an example of how one community has articulated its requirements and created a process to ensure that its culture and interests are addressed in research projects that want to involve its members. It also reflects Principle #3, the building of trust and strong working relationships between community members and researchers. Principle #8 is implicit in the protocol that was created — the researchers must be prepared to revise their approach, as requested by the community. The research protocol reflects a long-term commitment by recognizing that the community's interests continue beyond the time frame of any one particular project (Principle #9). Although this example involves research, the concepts and process are relevant to virtually any community-based initiative.

In response to an increasing number of environmental and other types of research projects being proposed in their area, members of the Mohawk Nation community of Akwesasne in upstate New York established a protocol for reviewing research proposals. The protocol is a blend of cultural philosophy and pragmatic response to operational issues and concerns. In addition to presenting guidelines for conducting research that draw from the community's cultural ideals, the protocol outlines numerous requirements to ensure community participation in all stages of research, from planning through dissemination of the results. The protocol also requires researchers to describe the benefits and risks to individuals and the community as a whole, and to address such issues as informed consent, intellectual property rights, and data ownership.

The review of research proposals is overseen by a community-based organization, the Akwesasne Task Force on the Environment, whose mission is to "conserve, protect, and restore the environment, [and] natural and cultural resources" within the Akwesasne territory. The Task Force reviews behavioral, social, and medical research proposals as well as environmental studies. Their approval is required before any research can be conducted in the community.

The review process is characterized by the Task Force as "a guide to improve relations between the community of Akwesasne and scientists/researchers, and to promote collaboration within the framework of mutual trust and cooperation." The ultimate objective is the development of "a good research agreement," which they have defined as something that will "result in shared power, shared resources, and mutual understanding and will ensure that studies proceed in a manner that is both culturally sensitive, relevant, and beneficial to the participants and community of Akwesasne."

The following excerpts from the "Definitions" portion of the protocol illustrate the views of the community on a variety of issues:

• Empowerment: "Empowerment is defined as a sharing of power and the result of a good research agreement developed by both the community and the researcher. Each of the participants feel that their needs are being met and that their credibility is increasing. Partnership and responsibility continue to grow as more and more respect and equity enter the agreement....Empowerment also means that authorship must be shared between the community and the researcher...."

• Equity: "Equity is defined as a sharing of resources. Both the researchers and the community must bring equity to the agreement. Each of the participants in a good research agreement must evaluate this equity in relationship

to the research. Finance or money is only one form of equity. Community knowledge, networks, personnel, and political/social power are other forms of equity. Each of these commodities has value and must be shared between the researchers and community if a good agreement is to be formulated. It will be necessary to review equity over the duration of the agreement."

• Respect: "In order to develop a good research agreement, the researchers and the community must generate respect for each other. Respect is generated by understanding each other's social, political, and cultural structures. The researchers and the community cannot assume they believe in the same things or share the same goals and expectations....Definitions and assumptions must be clarified and questioned by each side. The community and the researchers must listen to each other with clean, clear ears. Consensus and a mediation process will be used to develop the procedures which can be honored by both the researchers and the community."

The protocol identifies a number of specific areas of concern with regard to the collection and dissemination of research data. In addition to requiring that researchers spell out the benefits and risks (including physical, psychological, social, and cultural risks) that might result from the research, the protocol sets forth strong confidentiality requirements and mandates that data be shared with the community before disseminating them more widely. It also requires that members of the community be given priority in employment and training opportunities associated with the project.

Finally, researchers are also required to undergo cultural sensitivity training and establish communication strategies for keeping the community informed about the progress of the research project. The protocol indicates that the community's interests continue even after the project is concluded, with requirements for community involvement in such things as commercialization of the research findings.

Source:
Akwesasne Task Force on the Environment, Research Advisory Committee. *Protocol for review of environmental and scientific research proposals*. Hogansburg (NY): Akwesasne Task Force on the Environment, Research Advisory Committee; 1996.

National Cancer Institute: ASSISTing Change in Community Health
American Cancer Society Affiliates, State Health Departments, and Community-Based Coalitions
Detroit, MI

Although smoking is an individual behavior, tobacco use is increasingly seen as a broad public health issue because of the significant influence of social and environmental factors in the initiation of smoking and the decision to quit, and because of the effects of second-hand smoke on non-smokers. A national program to reduce smoking, called ASSIST, is focusing primarily on the community as the most appropriate level for implementing smoking control interventions. The program is based on a model which, consistent with Principle #5, stresses the need to establish partnerships with community organizations and to provide resources that allow communities to undertake their own public health strategies. This flexibility in meeting community needs (Principle #8) means that local coalitions can determine their own interventions. A local ASSIST coalition in Detroit recognized the need to be involved over the long term to ensure that positive public health actions occur (Principle #9).

The American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) is a partnership of national, state, and local organizations concerned with reducing the incidence of tobacco-related cancers. The program's objectives, which are directed toward both smokers and the general public, include policy changes, media advocacy, and prevention activities at the community level. These prevention activities are designed to encourage smokers to quit and to strengthen the norms and values that support non-smoking.

Each ASSIST program uses the same multi-level partnership model. Community-based coalitions that include voluntary health organizations, such as local affiliates of the American Cancer Society and others who have a history of involvement in cancer prevention and networks of volunteers implement smoking control strategies.

At this local level, individual community members and grass-roots groups become involved in the process, and are assisted by community-based, state, and national agencies and institutions (see the Detroit ASSIST Coalition description, which follows). Individual ASSIST programs are administered by state health departments, which offer experience in working in partnerships to achieve public health goals and a guaranteed continued presence. At the national level, the National Cancer Institute provides funding, the smoking cessation and prevention technology that has been developed from years of scientific study, and other technical assistance.

The following assumptions underlying the ASSIST program model reflect the partnership aspects of the principles of community engagement:

• When a community affected by change is involved in initiating and promoting the development of that change, there is an increased probability that the change will be successful and permanent. This involvement includes participation by community representatives in defining the problem and in planning and instituting steps to resolve the problem.

• Staff energies should be devoted to building capacity within the coalition and the site rather than to directly carrying out interventions.

• ASSIST resources will augment the existing resources of coalition members and other community organizations to accomplish ASSIST objectives. Rather than supplanting resources, ASSIST will stimulate and enhance existing resources to expand beyond their current smoking control activities. Conversely, ASSIST staff resources will be amplified by contributions of coalition members and other community organizations.

Community-based coalitions are the centerpieces of the ASSIST program because they are seen as the "organizational structures best suited to mobilize larger communities for smoking control." The initial aim of ASSIST has been to increase the capacity of existing community groups and organizations to serve as smoking control agents, and to bring new organizations into the arena. Below is a brief overview of a coalition in Detroit, where the ASSIST program has been building on the state's previous tobacco control efforts.

The Detroit ASSIST Coalition

The Michigan ASSIST program supports seven local coalitions, including one in the Detroit area. The Detroit coalition, which was established in 1992, describes itself as an "advocacy and information network through which tobacco prevention and reduction [assistance]...can be provided to all sectors of the community." The local organizations involved in the Detroit coalition include voluntary groups, local health departments, academic institutions, religious groups, family groups, women's groups, minority groups, health professionals, and community service groups and neighborhood organizations.

A primary goal of the Detroit coalition is to ban tobacco advertising on billboards. The coalition is particularly concerned about the use of billboards to appeal to young people and people in low-income communities. This concern has been fueled by a city survey (conducted at the request of another community coalition), which found that more than half of the 41,000 billboards in Detroit advertised alcohol or tobacco products and that billboards are more common in low-income communities.

Members of the coalition are designated as leaders for specific advocacy strategies developed by the coalition. These include updating the results of the billboard survey, garnering support for a ban from the business community and government, and publicizing the issue in the media. The coalition reports that even with their successes, a continuing need exists to engage groups and strengthen their involvement in tobacco control activities. "While the project has been successful in maintaining a small core group who consistently participate in the activities, recruitment and training efforts will be strengthened to bring the objectives to completion as desired."

Sources:

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The Community Makes it a "SAFE NIGHT" for Public Health
City of Milwaukee Health Department and the Milwaukee Violence Prevention Coalition
Milwaukee, WI

Public health strategies for community engagement are being applied to violence prevention in Milwaukee, Wisconsin, a city that experienced a more than 300 percent increase in violent death and injury from 1983 to 1993. The city's health department responded to this alarming trend with SAFE NIGHT, an award-winning model program that helps communities develop the capacity to reduce violence in their neighborhoods and homes. The program incorporates Principle #7, which stresses capacity building for achieving community health goals, and Principle #9, which emphasizes long-term commitment.

In 1993, following a decade of dramatic increases in violence-related deaths and injuries, the City of Milwaukee Health Department and the Milwaukee Violence Prevention Coalition developed a model community-based prevention program to help reduce violence. This program, called SAFE NIGHT, combines education on relevant topics — such as risk factors, conflict resolution, and anger management — with family enrichment activities and community organizing initiatives.

The SAFE NIGHT approach is based on three objectives, all of which reflect the principles of community engagement:

- Enlist community support for forming an effective violence prevention tool.
- Use public health methods to help reinforce community efforts.
- Sustain prolonged violence prevention efforts with the community at large.

The SAFE NIGHT program has attracted strong support from citizen groups, police, hospitals, schools, and businesses. Nearly 50 community-based organizations and neighborhood groups are involved. Communities have taken ownership of the program, hosting violence prevention events weekly at numerous sites. In addition to developing SAFE NIGHT, the health department provides many of the program's capacity-building resources, including organizer kits, training sessions, and linkages to businesses that donate services.

Using the SAFE NIGHT model, the health department and communities in Milwaukee have become effective partners in controlling the local environment and reducing violence. To cite one example of its effectiveness: SAFE NIGHT has been credited with sharply reducing the number of children admitted to the emergency room with violence-related injuries at the city's Children's Hospital. Similar successes are expected as the program spreads throughout the city and state.

Source:

National Association of County and City Health Officials (NACCHO). J. Howard Beard Award winners honored at the National Association of County and City Health Officials, Annual Conference. *NACCHO News* 1996;July/August:9.

Community Care Network
The Hospital Research and Educational Trust
Chicago, IL

As health care delivery increasingly focuses on community outcomes, local public health agencies and community-based organizations have become critical links to hospitals and health care providers, particularly in reaching the underserved and in the areas of prevention and health promotion. A national program is bringing these groups together in partnerships that emphasize the health status of the community overall and accountability to the community. This program reflects Principle #1, which recognizes that community engagement goals can vary, Principle #2, which requires becoming knowledgeable about the community, and Principle #3, which addresses the need to establish relationships with recognized and trusted community groups. Individual communities are able to determine their own program goals and strategies within this national program (Principle #4). The entire program is based on Principle #5, which states that community partnerships are necessary to improve health.

The Community Care Network (CCN), a program operated by the Hospital Research and Educational Trust, has created partnerships among local health care providers and community institutions, including public health and social services agencies as well as other community-based organizations. Other national groups involved in CCN include the American Hospital Association, the Catholic Health Association of the United States, and the Voluntary Hospitals of America, Inc. The program is supported primarily by the W.K. Kellogg Foundation, with additional funding from the Duke Endowment.

CCN, which was established in 1994, supports projects in 25 communities with diverse populations ranging in size from fewer than 15,000 to more than 1 million. The health concerns of these communities often involve issues of access, whether in terms of geographical access, availability, cost, or insurance coverage.

The goal of CCN is to integrate community-based organizations and perspectives into the local health care system. Local public health and social services agencies play a central role in the CCN program because of their position within the community. As one federal health official describes it:

"Local health departments have a significant and rich history in building coalitions to bridge any gaps or deficiencies in services...; they have done so much work with hard-to-reach populations; they have been heavily involved in community health education...; and they have experience in providing technical assistance. All this has given them credibility within their communities."

This credibility is a key element in engaging community support for the kinds of health initiatives supported under the CCN program.

Under CCN, the objective of improved coordination and management of service delivery is tied to a focus on the health status of communities, not just that of patients or health plan enrollees, and to "community accountability." Different CCN projects are implementing these concepts in different ways, and they typically involve a variety of organizations. For example:

• To the CCN program in Broome County, New York, community accountability means establishing "formal, accountable linkages among providers of health and human services, health planners, and educational system to allow for coordinated case finding and service delivery across the continuum." This approach reflects the diverse range of health concerns in the community, which is confronting high rates of AIDS, drug-related violence, heart disease, teenage pregnancy, and health problems relating to poverty. The Broome Community Partners Uniting for Healthy Families includes the local school district, health department, mental health agency, hospitals, and

charitable health organizations.

• In Lancaster, Pennsylvania, the CCN program has identified lack of access to primary care as a major health problem for the community. In this context, the program views community accountability in terms of providing services to the entire population, but they are specifically targeting the uninsured and the underinsured. In addition to health care providers and administrators, members of the Lancaster Community Care Network include attorneys and state and local government officials.

• The principal health concerns in Riverside, California, include a high rate of teenage pregnancy and high absenteeism from schools due to illness. Accordingly, to the Jurupa Community Partnership, accountability means community outreach through school-based community cultural events and health fairs and other activities that provide information about services and the CCN project. The original partnership, which included the social services department, the YMCA, a nonprofit youth service organization, and an elementary school, will soon be joined by a county health clinic and general hospital.

• The Rural Health Outreach Program in Arrington, Virginia, is placing lead responsibility for community accountability with a Community Health Council that provides oversight of the program's activities and will track health outcomes. Institutional members of the program include community health and social services agencies, county health and mental health agencies, a hospital, a university medical center, and a private managed care organization. They will be focusing on the community's high cardiovascular mortality rates due to chronic diseases such as diabetes and hypertension, and on such barriers to care as cost and geographic isolation.

Although CCN is a relatively new initiative, it is well on its way to improving public health in the communities in which it is currently operating. More broadly, it is providing an important new model for restructuring local health and human services delivery into a coordinated health care network that places greater emphasis on engaging the community.

Sources:

American Hospital Association, Hospital Research and Educational Trust, Catholic Health Association of the U.S., VHA Inc. Special Issue: On structuring public health. *CCN Vision* 1996;1(3).

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Networks for Community Health
North Carolina Community-Based Public Health Initiative
Chapel Hill, NC

An initiative sponsored by the W.K. Kellogg Foundation has promoted stronger links among public health educators, local health agencies, and community-based organizations in underserved communities. The goal of the Kellogg program is to change public health education and practice to make them more responsive to community needs. One state's Kellogg initiative is described here. Its policies and activities reflect several of the principles of community engagement: Principle #3, working with community leaders; Principle #4, community-self-determination; Principle #5, partnerships with the community; Principle #6, respecting community diversity; Principle #7, capacity building; and Principle #9, long-term commitment. Of special interest is their approach to assessing the existing capacity of organizations to address health-related issues.

For the past several years, 12 groups in North Carolina have been working together to address the public health needs of underserved minority populations in several communities. The groups include community-based organizations, local health agencies, and university departments. Known as the North Carolina Consortium, they are funded by a grant from the W.K. Kellogg Foundation's Community-Based Public Health initiative. The Kellogg program is based on the following assumption:

"Since all health concepts must ultimately have local relevance, there is a need for public health professionals — as well as for political, human services, and community leaders — to understand clearly the social, economic, and cultural conditions which determine health status and the manners by which these affect life style, behavior, and community decision-making."

The North Carolina Consortium is working to improve the health of targeted populations in selected communities. The communities themselves are identifying the specific issues and concerns to be addressed, while agencies and academic participants are providing technical assistance expertise. The consortium's approach is based on a non-traditional model of achieving social change, in which "implementation is more than a matter of pooling academic, service agency, and community-based resources. It is one of allowing an interorganizational network to set collaborative agendas and make collective decisions." Consistent with this approach, all members of the consortium have agreed to the following guiding principles:

- Participating community-based organizations should provide strong community support.

- The policy-making body of each participating organization should approve any Consortium initiative.

- The Consortium will designate specific communities with which to work.

- All partners are committed to implementing the community-based process and to acquiring needed resources.

- Each partner is willing to make the changes necessary in order for the community-based health initiative to become a reality.

The Consortium's community-based strategies are being developed and implemented by four county coalitions. Some of the coalitions already existed, while others were formed expressly for this effort. Like the umbrella Consortium, these four coalitions consist of community-based organizations, health organizations, and university participants. In planning the effort, the county coalitions were evaluated for their capacity to serve as the agents of change. Specifically, they were evaluated in terms of their interorganizational networks, as described above. This evaluation was critical to planning the initial objectives and activities of the different coalitions.

Each coalition was classified according to the level of network that existed among its members. Two coalitions were found to be in the formative, or "exchange network," stage. At this level, groups engage in "mutually beneficial exchanges" and other activities through which trust and common understanding are developed. In one of these two coalitions, the health organizations were already strongly linked, but they needed to develop relationships with the housing agency and residents council that were representing the community. The coalition strengthened those relationships by first addressing some health-related housing problems before moving on to more traditional health concerns. In the other coalition, the health initiative is being led by a community-based organization. Their initial focus has been on gaining community support for the initiative, assessing the community's health-related priorities, and developing the community's capacity for addressing issues of concern.

The Consortium judged that the third county coalition had progressed from this early stage to the "action network" stage in which organizations have some experience in jointly addressing a common problem but do not have ongoing collaborations. The community-based organizations in the coalition were able to respond collectively to a crisis, but they did not routinely work together. The initial challenge for this coalition was to establish structures and processes that would ensure that a network would be in place and responsive to the

community's needs on an ongoing basis. Among other things, the coalition began to participate in the "Community Voices" program developed by the Cooperative Extension program at North Carolina A&T State University as a tool to develop a community leadership base. The program goal is to develop groups of community leaders who can work together over time, both in identifying important issues and solving problems related to those issues. Particular emphasis is placed on reaching groups of emerging community leaders who traditionally have not been an active part of public decision-making in the communities.

The Consortium determined that the fourth coalition was at the advanced, or "systemic network," stage. At this level, groups collaborate on all tasks rather than having each organization assigned to accomplish a task alone. Decision-making power resides with the network. In this coalition, the participating community-based organization was itself an umbrella for a network of over 40 smaller community groups, and it already had an ongoing relationship with health agencies. It was clear that the coalition had the capacity to maintain a long-term presence and undertake complex projects. Their primary activity has been to establish a resource center that provides services in four main areas: community leadership development, economic development, health promotion, and minority student career development. This center is the home for such projects as a training program for community health advocates and a program in which hospitals and educators work together to improve the educational performances of children with health problems, and to provide access to health services for public school children in the area.

Funding from the Kellogg Foundation expired in September 1996, but the Consortium and coalitions are continuing their efforts while seeking support from other sources.

Sources:

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LINKING ENGAGEMENT PRINCIPLES TO PRACTICE

Before Starting a Community Engagement Effort. . .

Principle #1 emphasizes the need to articulate the purpose and goals of the engagement initiative. Its implementation involves assessing an organization's capacity for engaging the community and building or leveraging community assets for health improvement. Community engagement, like any other initiative an organization undertakes, needs to be implemented with a plan of action. The people and organizations engaged, the strategy and approach used to gain their involvement, and the resources needed within the organization and the community all depend on the purpose and outcomes desired.

Community engagement may or may not be a new way of doing business. If it is new, it may mean changing the way an organization makes decisions about its programs and allocation of resources. It may also mean developing partnerships, coalitions, and collaborative efforts with new people and organizations. Before action can occur, the organizational leaders need to consider and develop a management strategy. Everyone initiating the effort needs to be operating from the same level of understanding and from a similar framework.

A formal or informal assessment of an organization's capacity for and approach toward engaging the community involves looking at:

- The *values* of the organization (e.g., Does it perceive that it is important to involve the community in

identifying community health issues and developing programs? Does it recognize that partnering and collaborating with other groups or community-based organizations are important?)

• The *intent* of the organization (e.g., What is the best way to establish its position and select strategies to begin community action? Are authoritative approaches or cooperative approaches more appropriate?)

• The *operations* of the organization (e.g., Is it already working with the community around specific programs or issues? How? Are there existing collaborations with other institutions or agencies? Are community leaders or representatives already involved in decision-making related to program planning, implementation, and evaluation?)

• The *resources* and *expertise* available to support an engagement effort (e.g., What mechanisms will be in place to ensure that relevant data on community needs will be used? What financial resources will be required? Which staff are most skilled or already have strong ties to the community?)

In Thurston County, Washington, the health department used APEX/PH as a tool to assess their organizational capacity and goals for engagement. In this case example, Principle #1 was clearly implemented through the health department's identification of the purpose for engaging the community. Their approach also helped leaders of the engagement effort address Principles #2, 3, 4, and 5 with efforts to know the community, establish relationships and trust, allow community control, and develop partnerships for change. The approach used in this case was effective in gaining the community support necessary to strengthen community assessment and planning within the county.

It is also interesting to note the Thurston County Community Health Task Force's desire not to select priorities. Priority setting is important, but it can be counterproductive for long-term community engagement. If individuals feel that their interests are not part of the priorities of the group, they may leave the collaborative initiative and valuable resources can be lost. The community organizer may then be faced with an even more difficult challenge to regain participation from those segments of the community.

While the Community Care Network (CCN) initiative had an overall goal to integrate community-based organizations and perspectives into the local health care system, the way this goal was carried out in different parts of the country acknowledged different community needs. The goals and strategies in the CCN program in Lancaster, Pennsylvania, differed from the program in Riverside, California, because of different community needs and capacities. Therefore, this initiative adhered to Principle #1 in establishing a clear purpose and goals, but also fulfilled Principle #2 by becoming knowledgeable about the community in its various implementation strategies.

In articulating the purposes or goals of a community engagement effort, it can be valuable to think through a few key issues:

• Know what is of interest and what accomplishments are expected by involving the community. For example, is the goal a broad one, such as engaging the community in assessing the health status, identifying concerns, and developing and implementing action plans, as undertaken by the Jackson County Health Advisory Council? Or is it more narrow, such as engaging the community around specific health objectives (e.g., the National Breast Cancer Coalition's goal to foster progress in breast cancer research)?

• Have some idea(s) about how the community should be involved (e.g., as advisors or co-decision makers).

• Be clear on the community to be engaged, at least initially. Is it a geographic community, including all of those who live within its boundaries? If so, what is the size of the target area — a housing project, neighborhood, small town, city, or your organization's entire service area? Is it a specific racial or ethnic group, income-specific population, or age group? Is it a specific set of institutions or groups, such as neighborhood associations, community-based organizations, faith communities, or schools? Or is it a combination?

• Know the extent to which the focus of the community engagement efforts are flexible. As implementors learn more about the community and issues of interest, you may find it more effective or appropriate to focus engagement efforts on other populations or communities. Similarly, you may want to modify your goals based on community input.

As discussed in Part 1, the social science literature and principles suggest that there are several dimensions to the participation that comes with engagement. An organization's leaders and staff as well as community leaders and members will be more likely to become involved if they understand what it means to become involved and believe their participation will be meaningful.

Principle #2 asks organizations and community leaders to develop an understanding of the community they wish to engage. As this principle is operationalized, Principle #6 — recognition of community diversity — becomes increasingly important. For example, in Jackson County, Florida's community assessment, the local health department and church leaders recognized the importance of modifying their PATCH instruments to make them more culturally appropriate. In implementing Principle #2, public health agencies helped to develop a Health Advisory Council whose members defined the assessment strategies and collected data to support programmatic decision-making. They examined economic conditions, health status indicators, demographic trends, and community norms and values to determine the needs of the African American community in Jackson County and how best to meet those needs.

Applying Principle #2 includes one or, ideally, more than one of the following:

• Using census data, existing community profiles, and information from local planning groups and community organizations to improve understanding of such matters as the educational, racial/ethnic, age, income, employment, and health status of the population and to determine what is and is not known about the population.

• Becoming knowledgeable about the formal political structures and influences (e.g., city/county/ward/parish responsibilities and leadership, neighborhood governance, and community planning councils).

• Identifying key community organizations and institutions, getting to know the formal and informal leadership structure, and understanding the linkages among groups and the relevant health, human service, education service systems as well as economic development initiatives.

• Developing an understanding of community/population norms and values and how they may influence participation in engagement efforts, the community's health decision-making process, and their health behaviors.

• Learning about past and current efforts to engage the community around health or related issues, understanding what worked and did not work — and why — as well as how those efforts might influence a community's readiness or willingness to become involved again. Increasingly, groups and individuals in a community are already involved in coalitions and partnerships around specific issues, such as HIV/AIDS, substance abuse prevention, and community and economic development. It is important to consider how trying to engage or mobilize the community around other issues may affect these pre-existing efforts.

This understanding will help organizers map community assets, develop a picture of how business is done, and identify the individuals and groups whose support is necessary. Kretzmann and McKnight's *Building Communities from the Inside Out* can help identify and map community assets and resources (Kretzmann et al., 1993). CDC's PATCH also contains tools to help develop an inventory of collaborating groups and survey opinions of community leaders and members.

Learning about communities involves talking with people, attending community meetings, reading community newspapers, and obtaining information from current health providers and planners. It involves establishing relationships and building trust. Consider whether to initiate this activity alone or in partnership with other

institutions, public agencies, or organizations. In its use of the "key informant" process, the Thurston County case example describes an innovative way to begin a partnership with the community.

For Engagement to Occur, It Is Necessary to . . .

As discussed in Principle #3, establishing relationships, building trust, and working with community leadership are critical to create the processes for community engagement. In the Mohawk community of upstate New York, the community established its own definitions of true community engagement through its development of a research protocol. Any researcher seeking to work with their community must submit their proposals for review by the Akwesasne Task Force on the Environment. Through this sense of mutual collaboration and benefit, the needs of both the researchers and the community can be met.

The local health department in Thurston County, Washington, talked to community leaders to obtain their advice on membership of a Task Force. The National Breast Cancer Coalition started with many local support groups as its foundation. Church leaders were approached in Jackson County, Florida, to involve their congregations. North Carolina's Community-Based Public Health Initiative relied on four existing county coalitions to develop and implement new strategies. All of these locations found partners that had mutual interest and their collaboration offered mutual benefit.

In practice, work within communities is a continual effort of balancing benefits and sustaining cooperation and accountability among participating groups. All interested individuals, groups, and organizations with like interests must feel they have influence and can join a community collaboration. This is the foundation for trust among community collaborators. If trust is not present, relationships are guarded and commitments are tentative. Therefore, relationships must be built that are inclusive of the entire community. If participation, influence, and benefits are limited among partners with compatible interest, then distrust is likely and potential community assets may be lost. Being inclusive can create some organizing challenges. However, successfully overcoming these challenges will provide a greater return on the investment made by a community leader through greater involvement of community groups and the assets they bring to the process.

Inclusiveness can create a problem for a facilitator of a community engagement effort. The primary problem is managing the decision-making process if there is a need for formal governance of the collaboration. If this is the case, the community should be given an opportunity to shape the governance process and to provide input on decisions to be made by the governing structure. Such an approach allows the community to influence decisions through the governance structure they helped establish. Again, Thurston County, Washington, demonstrates how communities can identify a leadership structure that is trusted.

Further, for engagement efforts to occur, it is important to show how working together will be of benefit to community organizations and those served or represented by the organization. It is also wise to be prepared to offer strategies to the collaborative process that can achieve a small success quickly and reinforce the benefit of participation.

The acceptance of community self-determination, as articulated in Principle #4, is also clearly necessary. For example, issues of equity and empowerment were central to the Mohawk Nation's *Protocol for Review of Environmental and Scientific Research Proposals*. Researchers cannot assume that they know what is best for the community. Decision-making must occur on a partnership basis that results in shared power and mutual understanding. The work of the National Breast Cancer Coalition is also based on the same principle of self-determination and consumer rights. One of the Coalition's major priorities was to increase consumer involvement in every aspect of breast cancer research. Through capacity building and information dissemination, the members of the Coalition have become important voices in decisions about research projects that affect them directly.

The nationwide Community Care Network initiative, which links public and private sector resources in meeting community health needs, is implemented in adherence to Principle #4. Individual communities are able to develop and carry out their own program goals and strategies according to their self-identified health concerns.

For example, one part of the country may focus on decreasing teenage pregnancy, while another forms partnerships to address high cardiovascular mortality rates.

For Engagement to Succeed . . .

When it actually comes down to successfully agreeing upon and implementing the desired actions, several principles (#5-9) are particularly important. Principle #5, development of true partnerships, means creating relationships of mutual cooperation, benefits, and responsibility to ensure that results are achieved. For example, the Detroit ASSIST coalition has been able to partner with diverse organizations to reduce tobacco advertising on billboards.

Community diversity and its role in engagement (Principle #6) must also be an integral part of any approach. The North Carolina Consortium reflects this principle with its respect for the diversity of its implementing coalitions. Each of the four coalitions was in a different developmental stage — this diversity was an integral part of defining goals and objectives and determining first action steps. While one coalition worked on developing mutual trust and understanding, another coalition with more experience in working together was able to undertake more complex projects.

Principle #7 — identifying and mobilizing community assets — is important whether in using existing expertise to identify areas for community action or tapping into skills and resources to implement and refine these strategies. The SAFE NIGHT violence prevention program in Milwaukee identified and mobilized the assets of nearly 50 community organizations and neighborhood groups, while also providing them with capacity-building training sessions, materials, and other resources.

As Principle #8 implies, community engagement is a long-term process that requires community leaders to evaluate their roles over time. It is important that one remains flexible enough to meet the changing needs of the community. For example, while the ASSIST initiative includes global objectives to reduce tobacco use, the local partnerships mean that individual community coalitions can determine the most appropriate interventions for their community.

Over time, it may be appropriate for an organization to move away from a position as a lead agency to a position as one of many partners in a broader effort. In addition, organizations may find that they may no longer need to reach out to involve the community because it may be coming to them with requests (or even demands) for certain resources or programs. Organizational leaders should be prepared to respond. Such community action may require a re-examination and revision of community engagement purposes and goals. Or, the organization may find it is time to broaden community participation and engage new communities on new issues while nurturing existing collaborations.

Principle #9 asks the engaging organization for a long-term commitment to the community. For example, the Mohawk Nation's protocol recognizes that the community's interests continue beyond the time frame of the particular research project. Researchers must be prepared to address issues after the research has been completed, such as publication and commercial applications of the findings. SAFE NIGHT, Milwaukee's community-based violence prevention model, is also based on the idea that sustained efforts over time are needed. Despite the end of their Kellogg Foundation grant, the North Carolina Community-Based Public Health Initiative is continuing its coalition process, recognizing the need to sustain important efforts begun with the community.

CONCLUSION

Principles of Community Engagement has attempted to provide readers with insights into important organizing concepts found in the literature and in the experiences of community leaders. From these, we have drawn a set of principles and shown how they have been applied in real-world community engagement efforts.

The contributors to this book hope it will help public health professionals and community leaders to gain greater

insight into the science and practice that supports community engagement and mobilization. We know that an understanding of the science will better prepare health professionals and community leaders to practice the art of effective engagement in the diverse situations that communities face when they take action and make decisions to improve health and quality of life.

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For further information on community collaboration, visit the Public Health Practice Program Office Internet site at www.cdc.gov/phppo/ or contact Michael Hatcher at Mail Stop K39, 4770 Buford Highway, N.E., Atlanta, GA., 30341-3724 or email mth1@cdc.gov.

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For further information on community collaboration, visit the Public Health Practice Program Office Internet site at

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