Contributions of Community Building

to Achieving Improved Public Health Outcomes

Final Report

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Introduction

The purpose of this paper is to explore the contributions of community building to achieving improved public health outcomes, and to examine why and under what conditions this linkage exists. The paper was commissioned by the Aspen Institute Roundtable on Community Change, along with two others that seek to describe the links between community building strategies and the outcomes of community development (e.g., housing and economic development) and civic engagement. The three papers will be used by the Aspen Institute to develop a final report to the Annie E. Casey Foundation.

To some, the relationships between community building and improved public health outcomes hardly require further evidence. When we interviewed people in the course of developing this paper, we often heard comments such as "Yes, of course community building produces better public health outcomes. Isn't that obvious?" Or, "Do you mean that someone would try to improve public health in a community without paying attention to community capacity through community building?" However, the reality is that many public health interventions are not coupled with community building strategies; and many groups undertaking community building do not include measures of improved public health as an outcome of their activities. Thus, in the search for evidence to build the case for these relationships, we explored the following questions.

First, could we find evidence from formal evaluations of measurable change in public health outcomes as a result of community building initiatives? Second, could we identify how, why and under what conditions community building strategies might result in improved public health outcomes, either measured by changes in risk factors or health status? Third, if we could not find empirical data to support the case, could we find less formal evidence that would help communities, policy makers, and funding organizations to support and evaluate their initiatives. Given limited resources, growing interest in both community building and community-based public health interventions, increasing demand for accountability and outcomes, and continued health disparities across various population groups, we believe this analysis will be useful.

Following brief definitions of community building and public health, and initiatives that link the two areas, we explore the rationale and conditions under which community building results in improved public health, including issues associated with sustainability. We present a general conceptual model of these relationships and an example from the REACH Detroit Partnership, a multi-level community-based participatory initiative aimed at reducing the risk of diabetes and related health problems. We also use examples from other initiatives to illustrate major themes. We close this paper with a discussion of the challenges of formally evaluating the impact of community building strategies on public health outcomes and discuss recommendations for further work in this area.

Methods

An initial draft of this paper was developed following a review of literature associated with community building, community capacity, community-based participatory research and public health outcomes. The draft included definitions of community building, public health, a brief history of the development of linkages between the two areas, the rationale and assumptions about these linkages and those related to sustainability and evaluation, as well as a conceptual framework and examples illustrating hypothesized relationships.

An iterative process followed, in which drafts were reviewed by individuals from academia and community organizations whose research and practice are community based, and whose work involved some aspects of community building and public health (Appendix 1). We recruited experts from several areas of public health and community building practice who also reflected geographic and ethnic diversity. These colleagues provided feedback on the drafts via interviews guided by a standard set of questions that were sent with the draft paper before the interviews (Appendix 2). The discussion format was conversational, which allowed for additional ideas to arise naturally. A final draft paper was sent to a separate group of experts with similar credentials (Appendix 1). This second group reviewed the materials in preparation for a facilitated group meeting, which was conducted in New York City on May 24, 2004, at the Aspen Institute offices. The meeting began with discussion of the draft paper, including its conceptual framework and assumptions. Each participant briefly presented examples from their own work, or that of others, which could contribute to evidence or understanding of the linkages between the community building and public health. The meeting concluded with recommendations for research, policy, and practice, with a focus on conditions needed to achieve and document success in linking community building to improved public health outcomes. The results of the interviews and meetings were combined to prepare the final paper.

What Is Community Building?

Community building has many interpretations. Community building is a process aimed at strengthening the capacity of individuals and organizations to develop and sustain conditions that support all aspects of community life (Blackwell & Colmenar, 2000). These processes engage people and organizations as parts of a dynamic system to build capacity to operate consciously as a community (Walter, 1997). Community building may be defined as:

> continuous, self renewing efforts by residents and professionals to engage in collective action, aimed at problem solving and enrichment, that creates new or strengthened social networks, new capacities for group action and support, and new standards and expectations for the life of the community (Blackwell & Colmenar, 2000, pp. 161).

Community building aims to expand and strengthen informal ties among community residents and to link community members to supportive individuals, organizations, and resources outside the neighborhood (Kubisch et al., 2002). Community building also refers to holistic approaches to build social capital and address systemic problems in communities, through development of partnerships and policies that promote community participation, address issues

of race and ethnicity, reduce isolation, and strengthen families and neighborhoods. (Blackwell & Colmenar, 2000; Minkler, 2004).

Community building is believed to contribute to a variety of outcomes important to the community such as improved economic opportunity, housing, safety, health status, physical infrastructure, and strengthened social relationships that provide mutual support. Community building efforts have largely been supported by the nonprofit sector and various government initiatives. According to Dorothy Ridings, CEO of the Council of Foundations:

> Since the early days of organized philanthropy, philanthropists like Andrew Carnegie, John Rockefeller, Margaret Olivia Sage, and Frederick Goff (who created the first community foundation in Cleveland, Ohio), were motivated by the desire to give back to their community so community building is not a new issue, although it has been popularized and improved in the past fifteen or so years through the growth of community development corporations and a renewed focus on community revitalization and citizen involvement. (Ridings, 1997, pp.1)

For the purposes of this paper, we began with a framework from Chaskin et al. that categorized the participants in community building interventions as individuals and organizations, using such strategies as leadership development to build capacity and community organizing to build connections with the aim of increasing the capacity of and connections among participants (Chaskin, Brown, Venkatesh, & Vidal, 2001). We have expanded upon this framework by adding a third, community - level since communities are more than the sum of individuals and organizations (Table 1).

Communities exist in a broader environmental context, with external forces that influence and provide resources for both community building strategies and public health outcomes (Freudenberg, 2004). In our adapted framework, community-level strategies include building community capacity by developing a shared community vision and norms, and by community-based planning. Community building in this context also includes fostering community connections and relationships that lead to obtaining knowledge, skills, and resources, and influencing policies that lead to improved community health outcomes (Goodman et al., 1998).

TABLE 1 Levels of Community Building Strategies and Intended Results

Level	Capacity	Connection
Individuals	**Leadership Development**	**Community Organizing**
Organizations	**Organizational Development**	**Coalitions Networks**
Communities	**Visioning and Planning**	**Relationship Building, Resource Development**

Community-building strategies include leadership development activities such as identifying current and potential community leaders and strengthening their capabilities through training, mentoring, and peer support in such areas as communicating effectively; mobilizing residents; planning, administering, and evaluating programs; developing and managing budgets and human resources; and conflict resolution. Community building aims to increase individual, organization, and community connections, both within and external to the community through relationships, coalitions, and networks. (Blackwell & Colmenar, 2000; Ewalt, Freeman, & Poole, 1998; Walter, 1997).

Additional examples of community building strategies include promoting community resident and organization participation in program planning, policy development, and resource development and allocation; increasing capacity to develop and implement problem solving and decision making processes; developing relationships and partnerships among community residents, organizations, and with institutions both within and external to the community that provide resources and services; developing community-controlled resources/assets; increasing capacity to reach out to and organize community residents through personal contacts, meetings, use of media, and formation of associations; developing or improving governance processes and increasing resident and organization participation in those processes, including voting; developing or implementing better tools for collection, interpreting, and communicating data, including broader resident participation in these processes.

What is Public Health?

The primary goal of public health is the protection and promotion of the public's health. Typically, research, surveillance, policies, and programs in public health are focused on the patterns and factors associated with understanding and improving the health of populations (instead of individuals), including reducing risk factors and strengthening protective factors. These factors go beyond health care to include social, economic, political and physical environmental conditions which affect people's health. A fundamental philosophy underlying the field of public health is that society has an interest in assuring the conditions in which people can be healthy (Institute of Medicine, [IOM], 1988). In 1994, the U.S. Public Health Service created a vision statement: H*ealthy People in Healthy Communities*, which defined the mission of public health as promoting physical and mental health and prevent disease, injury and disability. The field of public health works toward goals of preventing epidemics and the spread of disease,

protecting against environmental hazards, preventing injuries, promoting and encouraging healthy behaviors, responding to disasters, assisting communities in recovery, and assuring the quality and accessibility of health services (Public Health Functions Steering Committee, 1995).

The public health field embraces a wide spectrum of roles that relate to prevention of ill health (physical and mental) and its environmental, social, behavioral, and biological risk factors. Public health also includes the promotion of the wellbeing of the population. Its functions relate to a variety of health-related conditions, risk, and protective factors. The 1988 Institute of Medicine Report, *The Future of Public Health*, identified the core function of public health as assessment, policy development, and assurance. According to the U.S. Public Health Service, the 10 essential services of public health are: 1) monitoring and reporting on population health status; 2) diagnosing and investigating community health problems and hazards; 3) informing, educating and empowering people about health problems; 4) mobilizing community partnerships to identify and solve health problems; 5) developing plans and policies; 6) revising and enforcing laws that protect health and safety; 7) linking people to services and assuring health care; 8) assuring a competent work force; 9) evaluating effectiveness, accessibility and quality of services and programs; and 10) doing research for innovative solutions to health problems (Public Health Functions Steering Committee, 1995).

Most health outcomes are affected by complex interactions of factors, many beyond the immediate control of individuals or community-level organizations. Some traditional public health strategies (notably regulating and monitoring water and air quality and sanitation systems) take place at the community level but affect the health of individuals. Other strategies, such as immunization, require actions focused on individuals (even if done on a mass basis) that ultimately protect both individuals and the population. Thus, planning and evaluating public health interventions requires an understanding of the characteristics and relationships among each "targeted" health condition, its risk and protective factors (e.g., who, what, where, when, and why does risk or protection occur), and the societal, community, neighborhood, family, and individual contexts within which each operates or is influenced, and within which interventions may be done to reduce risk and/or promote protection of individuals and populations.

In recent years, public health practitioners and researchers have increasingly recognized that many of the social and physical environmental determinants of health require that public health expand its conceptualization of mission and scope of activity to include non-traditional partnerships with professionals, community organizations and residents concerned with such areas as housing, transportation, economic development, architecture, recreation and others.

Community-Based Participatory Approaches to Public Health and Their Links to Community Building

The field of public health began emphasizing community participation in health-related planning in the 1960s, particularly after the development of the neighborhood health center movement in 1965 as part of the War on Poverty (Minkler, 2004; Turnock, 2004). These federally qualified centers provided (and continue to provide) preventive and primary health care to medically underserved communities throughout the country, under the direction of community boards. The emphasis on community-based participation in planning and implementing initiatives promoting public health continued to expand during the 1970s and 1980s. In 1986, the World Health Organization (WHO) adopted an approach to health promotion that emphasized the importance of people's control over the determinants of health, public participation and inter-sectoral cooperation (Minkler & Wallerstein, 1997). The WHO also initiated the *Healthy Cities* and *Healthy Communities* movements, involving U.S. public health service agencies, foundations, and other organizations that focused on developing and sustaining physical and social environments needed for health. Beginning in the 1980s, community organization strategies were adopted as part of efforts to combat the growing AIDS epidemic (Minkler & Wallerstein, 1997). Stimulated by the broader concepts of public health outlined in the landmark 1988 IOM report, community assessment and policy development in public health increasingly emphasized community development, partnership and coalition building strategies (Turnock, 2004).

In recent years, there has been a growing recognition that "community capacity represents both a necessary condition, an indispensable resource, and a desired outcome for community [health] interventions" (McLeroy, Norton, Kegler, Burdine, & Sumaya, 2003, pp 531). In response, many public health planning models have included specific community building strategies. For example, Planned Approaches to Community Health (PATCH) emphasizes community organization; mobilization and constituency building among community residents and leaders; assessment of organizational structure; and capacity and development of community capacity building plans (Minkler & Wallerstein, 1997). The W.K. Kellogg Foundation has funded a wide range of initiatives aimed at strengthening programs and policies that influence public health. For example, the Turning Point initiative engaged partnerships of community and governmental organizations in 41 communities to assess needs, prepare action plans, develop programs and build relationships needed to sustain the work (Lewin Group, 2003). The Kellogg Foundation's Community Based Public Health Initiative "integrated community, academic, and community organization assets to overcome structural, environmental, political, and economic barriers to achieving essential health outcomes through community-based participatory research, teaching, and practice" (Bruce & Uranga McKane, 2000, W.K. Kellogg Foundation). The IOM-recommended Community Health Improvement Process (CHIP) includes community stakeholder and partnership processes for developing a shared vision, planning, asset and resource development, and evaluation measures that include community accountability (Turnock, 2004). The California Endowment funded several community-focused initiatives in collaboration with the Public Health Institute, including the California Healthy Cities and Communities in 1998, and the Partnership for the Public's Health in 1999. Both support community building initiatives aimed at strengthening capacity and

sustainability to address social and environmental determinants of health (www.partnershipph.org and www.civicpartnerships.org).

The Centers for Disease Control and Prevention (CDC) provided support to community based participatory Urban Research Centers (URCs) in Detroit, New York, and Seattle between 1995 and 2004 (Israel et al., 2001). These community-academic partnerships initially focused on increasing the capacity of community organizations and residents to participate in community health assessment, collaborative planning and decision making and grant writing. For example, the projects conducted by the Detroit-Community Academic URC (Detroit URC) involved community residents and organization leaders in the process of designing, conducting, and analyzing data from community surveys, focus groups, organization meetings and community forums that were used to develop successful grant proposals that brought resources necessary for change. Each of these partnerships has subsequently received many funded community based participatory public health intervention research projects in the three cities. This report will include examples from several of the projects affiliated with the Detroit URC.

In 1999, the Centers for Disease Control and Prevention (CDC) initiated the Racial and Ethnic Approaches to Community Health (REACH 2010) community-based interventions (Giles et al., 2004).These projects, which are currently operating in 42 communities, began with a planning year during which they built or strengthened their community-based partnerships and developed a Community Action Plan. These plans, while unique to each community, share a common "logic model" evaluation framework that explicitly links community building strategies such as *capacity building→ targeted actions→ change among change agents and systems change→ public health outcomes, specifically, decreases in risk behavior and increases in protective behavior and, ultimately, elimination of disparities in health status*. Because of this design, these projects should ultimately provide evidence linking community building strategies to public health outcomes. Health issues being addressed include: diabetes (25 communities); cardiovascular disease (19 communities); breast or cervical cancer (6 communities), immunization (4 communities); HIV/AIDS (3 communities); and infant mortality (3 communities). Fifteen communities are addressing multiple health issues and five communities are Native American communities focusing solely on capacity building (Giles et al., 2004).

Community building strategies intersect with, and complement, major principles of community-based public health (CBPH) and community-based participatory research (CBPR). These increasingly respected approaches to public health practice and research emphasize internal (community-based) locus of control and strengthening community capacity, without discounting the need for action to address broader determinants of health (Israel, Schulz, Parker, & Becker, 1998; Goodman, Wheeler, & Lee, 1995; Minkler, 2000). Partnerships of community residents and organizations, health and other service providers and academia work collaboratively from project inception through implementation and evaluation. (Israel et al., 1998). CBPH and CBPR explicitly focus on identifying and developing community assets and strengths and building community capacity to address health-related problems and their underlying risk factors. Social action and change are integral parts, and the ultimate aim, of these processes. These approaches to public health research and intervention contrast with two other common patterns of public health practice: individual client services (directed at groups that are under-served by the private medical sector) and population-based public health which, while

placed in communities, is usually externally directed and offered without the participation of the "target population;" (Schulz, Krieger, & Galea, 2002 Jun).

Rationale for Linking Community Building and Public Health

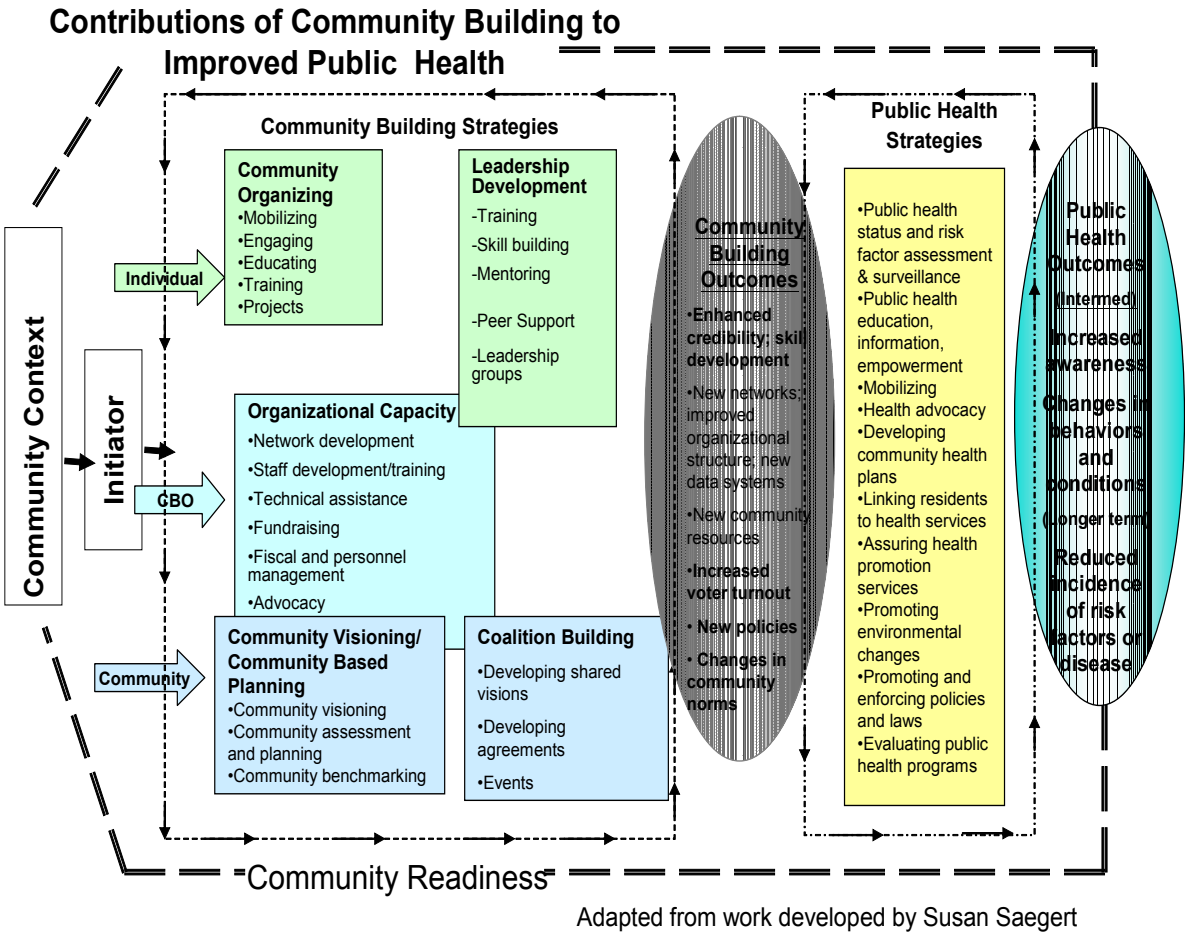
Historically, many public health interventions required little inherent community capacity. Examples of successful, but largely externally controlled interventions include the development of water and sanitation systems that led to dramatic reductions in morbidity and mortality in communities. In response to outbreaks of immunization-preventable diseases, public health professionals have used mass media and the formal public health system to organize and promote immunization campaigns that succeed in ending an epidemic and protecting the population for some duration of time. However, such initiatives must be planned and organized each time they are needed, they address only one health problem at a time, and many people may remain unprotected, particularly those who distrust or lack access to the health care system.

Many of today's health problems, particularly those causing large health disparities in marginalized communities, have complex causation and require similarly complex and long-term interventions. For example, type 2 diabetes develops after years of worsening metabolic status, reflecting the cumulative effects of such factors as physical inactivity, overweight, and diets that are low in fiber, fruits and vegetables, and high in certain fats. Communities with high diabetes prevalence often contain physical and social barriers to healthy behaviors, such as unsafe neighborhoods, few or no recreational facilities or grocery stores, social stressors, and competing demands on residents' time and energy (Kieffer et al., 2004). Social and behavioral norms that arise from these conditions (e.g., shunning outdoor recreation, eating high fat convenience foods and little produce) also make health-promoting behavior more difficult. Both prevention and control of diabetes require a combination of environmental, social, and behavioral strategies that reduce community, social and individual barriers to weight control, regular exercise, and healthy eating practices. To address such health problems, community health interventions that include community building strategies are more likely to result in improved public health outcomes by enhancing community capacity and facilitating community empowerment (Minkler, Thompson, Bell, & Rose, 2001).

In summary, community building strategies are believed to create or increase the capacity and connections between individual, organizations and the community-at-large and to those outside of the community that will lead to growing community awareness of the causes and methods for prevention or amelioration of health problem, and readiness and empowerment to engage in change. These processes also lead to development of, and increased access to, resources necessary to successfully implement and sustain programs, policies, and related activities designed to reduce behaviors and conditions in the social and physical environment that are detrimental to health, and to improve or increase behaviors and environments that promote health. Sustainability is essential, given the duration of effort needed to achieve lasting change in most public health outcomes. The mission of achieving equity and social justice underpins both community building and public health strategies and outcomes.

Figure 1 represents a general model and examples of the linkage between community building and public health strategies and outcomes. The general consensus of the experts we interviewed was that while some of these relationships might, at times, be viewed as linear, e.g. community building strategies and outcomes as necessary first steps before public health strategies and outcome, the actual relationships are usually more complex and often circular. These relationships will be described in more detail in the following section.

Figure 1



Adapted from work developed by Susan Saegert

Why, How and Under What Conditions Community Building Contributes to Improved Public Health Outcomes

Identifying some of the parameters of the relationship between community building and public health should, over time, help practitioners and policy makers determine when community building strategies should be coupled with public health interventions, and which community building strategies may be most useful in various environments. These conditions were developed through readings and from the ideas generated during the interviews and facilitated meetings. Each is considered an important contributor to positive outcomes.

Community building leads to increased community awareness of public health issues and readiness to change that are essential steps toward improved public health outcomes.

To be effective and sustainable, interventions must be targeted to the stage of community readiness and capacity to change, and then build from there. An element of readiness is community awareness of public health issues, which is a necessary first step before building to program and policy development. This includes awareness of health-related issues and behavioral, social and physical environmental risk, and protective factors that contribute to the health-related outcomes. This awareness is essential to the development of the political will, identification of resources needed to address these factors, and motivation of individuals and organizations to change. If the process of community building is attenuated, the intervention may be less effective (Goodman, 1996).

How the community identifies and embraces a particular health issue varies greatly. There often is a *community trigger*, an internal recognition of a threat or problem that is devastating to individuals and families. The initiator of this awareness may be internal, such as an affected person who may be a natural leader who has the ability to translate a personal tragedy to community outrage. This is perhaps best illustrated in the development of the Mothers Against Drunk Drivers (MADD). Examples of external motivation include the availability of funding that supports a community planning process or the provision of technical assistance to address a particular public health issue. Regardless of how the issue is brought to light, a second element that must be present is that the community must believe that something can be done to address the issue. In both situations, community building strategies may result in leadership that is able to stimulate community awareness of the extent and roots of the problem by bringing affected people together (increasing connections) to share their experiences and discuss its causes.

Another element of community readiness is the level of community attention, specific capacity and skill to address health issues, and community-serving power that is available within the community. Community-serving power may come from individual internal leaders, organizations, elected officials, or external sources. Community residents who do not have surplus time or are engaged in other critical life or community building activities, often cannot take on additional issues, regardless of how pressing they may be. In the Joyland/Highpoint community in Georgia, senior residents carried a large portion of the community building activities because of the time, wisdom, and skills they had available to serve the community.

In largely Latino Perth-Amboy New Jersey, the community had no primary health care and limited social services for youth, but had a strong and progressive Catholic church leadership that was respected by the community (Aguirre-Molina, 2004, personal communication). Several community leaders affiliated with the Catholic church invited medical school partners to work with them to address the issue of "too early childbearing." The church leaders, and subsequently other community leaders, agreed that turf battles between community organizations could be avoided by asking the medical school partners to write grants and take responsibility for fiscal administration. The resulting intervention reflects steady growth in capacity and connection building, with active student and parent involvement in issue identification, followed by activism (e.g., demanding action by the school board). Parent education and engagement became an organizing strategy. They effectively used external resources, and also became politically active. Outcomes include increased civic capacity (the first Latino and seven new school board members elected), and six year pre/post test surveys demonstrating that students were using safer sex practices.

Community awareness and readiness to change may be enhanced by participation in community planning processes.

Community awareness and readiness to change may be stimulated by community participation in identifying and understanding community health issues and their context. We believe that this involvement is essential to the success of public health initiatives, since an otherwise well-designed program or policy may fail without a basis in community realities, and community agreement regarding the program's importance and activities. For example, in many communities the recent introduction of tobacco settlement funds created a "disconnect" between the perceived concerns of communities about the most important public health issues they face and the funding available for community planning of this externally imposed priority. If the community does not see the importance of planning for tobacco use prevention and control compared to an epidemic of community violence, a real community response is unlikely to emerge despite the presence of funding.

Community building strategies that actively engage community residents in a more open-ended planning process are more likely to be successful. In 2000, the Detroit URC-affiliated project, the REACH Detroit Partnership, invited families from eastside and southwest Detroit to discuss their perceptions of a range of health issues, including diabetes, high blood pressure and cardiovascular disease. These topics had arisen from previous research in which community residents planned, implemented and participated in community surveys and focus groups. During this round of planning focus groups, community residents identified diabetes as having a serious and widespread impact on their families and community. They discussed their beliefs about its causes and impact, barriers to healthy eating and exercise practices, and recommendations for action. Their ideas, which were subsequently confirmed in community organization meetings with other residents, spanned societal, community, family, and individual contexts. The resulting complex intervention design responded to community recommendations about how to reduce barriers to health promoting behavior and health care. Many participants said that the process increased their connections to other community members facing similar challenges and helped them learn from each other about diabetes-related causes, risks and management strategies. Several volunteered to participate in the next stages of planning.

Organizing and strengthening connections within the community, and between the community and others outside the community, contributes to community readiness to change.

Galvanizing social networks, community-appropriate communication strategies and use of various media to raise community awareness of health-related issues may eventually lead to changes in community expectations and norms (Goodman, 1996). This may begin within the community, but community building strategies may also result in increasing connections between community leaders, policy makers, or media and business owners who then respond to community demands for change. Community building also involves the building of skills needed to organize and mobilize social movements. Examples of these linkages include community opposition to cigarette and alcohol advertising targeted to community youth and the location of toxic waste sites in low-income communities. This form of community building may also result in growing community awareness of, and interest in responding to, broader social trends that result in changing community norms such as treating drunken driving and domestic violence as unacceptable, or breastfeeding as acceptable.

Organizing and strengthening connections within the community and between the community and others outside the community contributes to successfully implementing and sustaining public health programs and policies.

When community building projects encourage or develop civic engagement, e.g. education about issues, budget and legislative processes, and political participation, sustained action and increased community influence and power are likely results. In addition to fostering connections within communities, community building strategies developed essential connections to funding organizations and policy makers external to the community for participants in Detroit URC-affiliated projects. Community organization leaders and community residents developed skills in presenting the methods and results of their activities at local, state and national professional meetings. In doing so, they established connections with policy makers, researchers, and funding organizations both inside and outside of the community. Recently, community residents from the Eastside Village Health Worker Partnership and the Healthy Environments Project presented testimony to the state legislature regarding neighborhood stressors and Detroit women's health on behalf of the Michigan Women's Commission (Schulz 2004, personal communication). They emphasized the importance of community-level change strategies to improve women's health in Detroit.

Community resident members of the REACH Detroit Partnership staff now serve on statewide policy advisory committees related to prevention and control of diabetes, data and measurement, and the role of community health advocates. Several state and city organization leaders serve on the community steering committees of other projects such as Promoting Healthy Lifestyles Among Women, Healthy Mothers on the Move, and Promoting Healthy Eating in Detroit. These connections result in mutual exposure to, and learning from, the perspectives and experiences of all participants, and increase opportunities for building linkages and developing resources. Collectively, these URC-affiliated projects in Detroit have built community capacity to examine and interpret factors related to health and to use this knowledge to influence policy

change. These efforts have also begun to result in commitment of resources by state and city agencies to previously under-served neighborhoods.

Successful project implementation that results in actual changes in community conditions or behaviors can create readiness for additional change.

Schulz, Krieger and Galea have emphasized that "interventions at the local level that have tangible and immediate benefits for local residents are an essential part of building trust and strengthening the social relationships between members of the partnership. Building strong partnerships is a first step toward building capacity to work for macro-level change" (Schulz et al., 2002, pp.292). In many communities, the driving cause for making changes in the community may be a desire to reduce the causes or impact of a particular health condition. For example, in the REACH Detroit Partnership, the community's initial reason for working together was to prevent the development of diabetes and its complications among community residents (Guzman, 2004, personal communication). In other communities, the antecedent may be a desire to strengthen the ability of the community to work together on other important issues. Where or on which topic or strategy this process begins may vary depending on the point of reference or perspectives of the participants (e.g., citizen, health care worker, policy maker, institution, etc.). Rather than being strictly linear (i.e., community building outcomes leading to improved public health outcomes), the relationship is often more dynamic, with one result building on another. The entry point may vary depending on the capacity and readiness of the community, its organizations and various leaders. Further, when improvements occur with one set of strategies, additional receptivity to other strategies may be created. Thus, improved public health outcomes may actually provide readiness for more and greater community building outcomes that may, in turn, increase the implementation of sustainable programs and policies affecting public health.

Detroit community residents have identified many barriers to healthy eating practices, including lack of grocery stores in the city. Community resident Eastside Village Health Workers had developed relationships built on shared activities promoting health-related projects in their largely African American community (Schulz et al., 1998; Schulz et al., 2002). They developed the concept of a fruit and vegetable mini-market that provided quality produce at wholesale prices within the public area of a trusted community organization. To operate the market required connections and partnerships among residents, community and city organizations, wholesale produce sellers, and the university, each of which shared their areas of expertise. Community awareness of the mini-market was illustrated when community residents described how it helped to increase the supply of fresh produce to their neighborhood during meetings held by other projects.

Community residents discussed the need to address both supply and demand for healthy food simultaneously. Their recommendations led to the formation of an expanded partnership (Eastside Village Health Worker Partnership, REACH Detroit Partnership, the Detroit Department of Health and Wellness Promotion, University of Michigan Schools of Social Work and Public Health and several community-based organizations and food-related organizations and business associations). This Detroit URC-affiliated partnership obtained a CDC grant, Promoting Health Eating in Detroit, to support the expansion of the mini-markets to predominantly Latino Southwest Detroit. This project has also led to expanded capacity building

activities at several levels. For example, Community resident Healthy Eating Advocates support the implementation of mini-markets and healthy food demonstrations hosted by community organizations; community restaurant owners are learning how to modify their recipes and menus. Community organizations are adopting policies to offer healthy food options for their public meetings, and community residents are learning how to form healthy eating support groups. Each of these activities are aimed at building awareness of the importance of healthy eating and also supporting personal, social and environmental changes that influence both demand for, and supply of, healthy food.

Building capacity through leadership development may be an essential precursor to implementing and sustaining programs and policies needed to improve public health outcomes.

Leadership development is a primary component of capacity building. It may be the precursor to implementing interventions focusing on community awareness and outreach activities. In order for these activities to succeed, the leaders' skills must be sufficiently developed and recognized within the community. For example, in indigenous and other communities that have experienced long periods of marginalization and disfranchisement, leadership development is a necessary "precondition" to community mobilization around a health issue (Bird, Braun, Burgess, DeCambra, Look, 2004 personal communication). In some communities, leaders have been controlled, subverted, or "bought" as a means of maintaining power and control by external forces (Bird, 2004, personal communication). In other cases, leaders have left their communities to seek stability or safety for their families. Without trusted indigenous leadership that can help identify health disparities and bring activism to the community, little action occurs. Leadership may be conceptualized in a traditional way, e.g., organization, political or church leaders; and in less formal ways, e.g., natural leaders (often women) in neighborhoods (Allen, Guzman, 2004 personal communication). Such leaders have the ability and respect of others needed to "make things happen." They can galvanize public opinion and organize resources needed to address public health problems (Freudenberg, 2004). Community building initiatives may provide important support for the development of the formal leadership skills of such individuals.

Building leadership capacity broadly (multiple people at various levels, refreshed by regular addition of more individuals) is important since each person has their own sphere of influence (e.g., organization, church, neighborhood, family) with its own web of connections. Broadly defined leadership development also protects against loss of community capacity. For example, the connections between a leader who is not indigenous or committed to the community may be fragile. If leadership development focuses solely on this person, or a few people, then the results of the development efforts may disappear if the person leaves. In the five-year expansion program of the California Healthy Cities and Communities (1998–2003), levels of pre-existing community capacity, including prior collaboration or coalition experience and structures, inter-organizational and social networks, a cadre of organizational partners, skilled leadership, and a community pool of willing volunteers, were mentioned by many participants as important influences on their success (Center for Civic Partnerships, 2003).

Organizational capacity building that leads to new or greater organizational skills may be necessary to launch and maintain public health programs.

Community building strategies should also result in strengthened organizational capacity and skills within community-based organizations. This level of capacity building better positions community organizations to apply for, receive and manage funds that can be used to maintain and sustain a public health improvement initiative. Similarly, organizational capacities to attract, hire, train, and retain community resident staff and to manage personnel activities contribute to successful and sustainable programs.

When the necessary skills are not apparent in the community, the community may opt to import certain capacities. In such situations, improved public health outcomes are most likely to occur when community building strategies serve to develop internal capacity that gradually replaces at least some of the imported capacity. For example, before interventions were developed, Morehouse University and organizations from the Joyland/High Point community in Georgia undertook capacity building for residents in areas such as community assessment, which included the conduct of surveys; board formation and maintenance, including use of parliamentary procedures; accounting, fundraising, and use of information resources (Braithwaite & Lythcott, 1989; Braithwaite, Murphy, Lythcott, & Blumenthal, 1989). The strong coalition that developed through these strategies has survived and thrived, addressing its initial area of concern, drug abuse prevention and continuing to address new issues such as diabetes. This coalition was also able to apply for, and successfully receive tax exempt status as a non-profit organization. Similar coalitions have formed and thrived using the strategies modeled by this project (Thompson-Reid, 2004 personal communication).

During the early years of the Detroit URC, most grant funds were received by the University of Michigan. In recent years, organizational capacity and sense of empowerment has grown and community organizations are more often the primary recipients of grant funds. For example, Community Health and Social Services, a federally qualified health center and member of the Detroit URC, is the grantee for two large, multi-year projects receiving millions of dollars: This organization now has primary responsibility for personnel, budget and intervention management; and project accountability to the federal and foundation funding agencies.

Adequate time must pass between initiation of community building activities and the expected stages of change needed to address the public health issue.

The development of community awareness, and readiness and capacity to change, require sustained attention to leadership and organizational development and the development and maintenance of internal and external connections to individuals, organizations and institutions that can provide sustainable resources necessary to support these changes. According to the findings of the California Healthy Cities and Communities evaluation, in which 20 communities received funding to engage in community health improvement efforts, it can take 18 months or longer for a community to conduct its planning activities and successfully transition to implementation (Center for Civic Partnerships, 2003). The CDC assumed that it would take several years for communities participating in REACH 2010 to implement the community-building phases of their projects before beginning to experience the expected changes in levels of

risk or protective environments and behaviors. Reduction in rates of disease and associated health disparities were assumed to require 10 or more years to be realized (Giles et al., 2004).

The nature of the public health problem influences both the time and resources needed to observe changes in health outcomes.

The impact of community building strategies on public health outcomes will be more difficult to measure for those that are rare or have complex or poorly understood causes. While most health problems are affected by multiple factors, some conditions have relatively clear and simple causation and rapid occurrence or onset (e.g., some infectious diseases such as measles or injuries such as bicycle falls leading to head injuries) may be easier to prevent than diseases with complex, interacting biological, social, and environmental factors risk factors and a long duration of risk exposure before onset, e.g., type 2 diabetes, cardiovascular disease, many cancers.

Public health education to develop community awareness and political support for a successful immunization campaign may, with adequate implementation resources, reduce the incidence of measles and its complications within months. Public education regarding bicycle helmet use could result in similarly rapid outcomes, but may require public policy (legislative) changes to require their use before such outcomes are realized. Conversely, some types of health outcomes, including most chronic diseases, have complex underlying causes that develop slowly. In fact, some reflect lifelong or intergenerational aggregation of risk. Diabetes and some pre-term births are examples of such conditions. Thus, both community building activities and related public health interventions must have adequate time and related resources to achieve their potential effects. Furthermore, resulting changes in behaviors and environments may need to be sustained for many years in order to result in sustained improvements in health.

Since there are well documented links between many intermediate public health outcomes such as changes in behavior and changes in the prevalence of some diseases (e.g. smoking and lung cancer; physical activity and type 2 diabetes), assessing the affects of community building strategies on intermediate outcomes is usually a more realistic and feasible option.

Community building strategies may be more successful when the population or community is well defined.

A clear sense of community identity may heighten awareness about health disparities and appropriate responses. For example, many cite increased attention to health disparities in the Native Hawaiian community following resurgence in Hawaiian identity and native rights through increased attention to culture, language, and values stemming from activism in the 1970s (Burgess, DeCambra, Look, 2004 Personal Communication). Increased community identity resulted in increased attention to health disparities and subsequent interventions. Similar connections may be evident in Native American, African American, Latino and other ethnic minority communities in the United States. Improved public health outcomes are also more likely to be noticeable in a specifically defined population or community than within the population at large.

Community building strategies influence internal and external control of risk and protective factors and resources that affect public health outcomes.

Community-building efforts are most likely to influence public health outcomes when both internal and external conditions are favorable to community change, including when the factors affecting health are within the power of the community to control or are affected directly by the availability of resources that the community controls. Community building strategies are also likely to result in improved public health outcomes when they achieve connections with people and organization that bring necessary resources into the community and influence external policies that affect community well-being. For example, a community coalition could engage residents in efforts to reduce pedestrian injury by conducting an educational campaign within the community, but success in reducing injuries is more likely to be achieved if community building efforts result in civic action and increased connections with city or state legislators that lead to the installation of crosswalks, speed bumps, street lights, and signs.

Community building strategies that promote development of community networks will have a greater impact on behaviors and environmental conditions that are within the reach of the network. For example, public health professionals, the New York City Public Housing Authority, and the housing tenants associations worked together to address the balance of issues associated with the use of pesticides in the public housing projects. Pesticides may cause health problems, but without their use, pests may increase, exacerbating the conditions that provoke asthma and other health problems of housing project residents. While some of these organizations had worked together previously, the problems resulted in an expanded, refreshed partnership that worked to identify and implement strategies to decrease spraying and pests, while creating jobs for housing residents involved in monitoring spraying practices. This model was also adopted by other housing projects (Freudenberg, 2004, personal communication). This example illustrates how working at the level of community control is likely to increase the potential for success.

A Detroit URC-affiliated project, Community Action Against Asthma (CAAA) provides an example of increasing community capacity at the family level (Parker et al., 2003). African American and Latino families in eastside and southwest Detroit participated in a randomized trial of a household intervention to reduce indoor exposure to asthma triggers. Families of children with asthma were randomly assigned to receive a home intervention immediately or, as part of a delayed intervention control group. After participating in training in environmental control of asthma, community residents were hired as Community Environmental Specialists (CESs). They provided families with asthma education, materials such as HEPA-filter vacuum cleaners and allergen mattress and pillow covers, integrated pest management (IPM) for cockroach and rodent control, social service referrals, and ongoing support. Preliminary results among the 200 families that completed the study suggest the intervention had a significant beneficial effect on children's lung function and was responsible for significant reductions in unscheduled medical visits and caregiver report of depressive symptoms.

Some public health problems require larger regional efforts or social movements that impact systems or policies well beyond the boundaries or specific control of the community. A project that grew from CAAA is mobilizing partner community organizations and community residents to raise community awareness of the causes and potential solutions to asthma risk factors that arise from outside of the community such as extensive diesel pollution from the large

volume of truck traffic that traverses the southwest Detroit community before and after crossing the international bridge to Canada.

Efforts to decrease chronic disease risk by improving the dietary practices of community residents require that residents have reasonably easy access to such foods. Several communities have used community building strategies to develop community awareness, demands for action, and most significantly, have increased connections with external resources that provide both the economic analyses (purchasing data) and political will to convince supermarkets to build in their communities (http://www.policylink.org/Projects/MarketCreek).

Community building must be an intentional part of public health initiatives in order for the results of both to be sustainable.

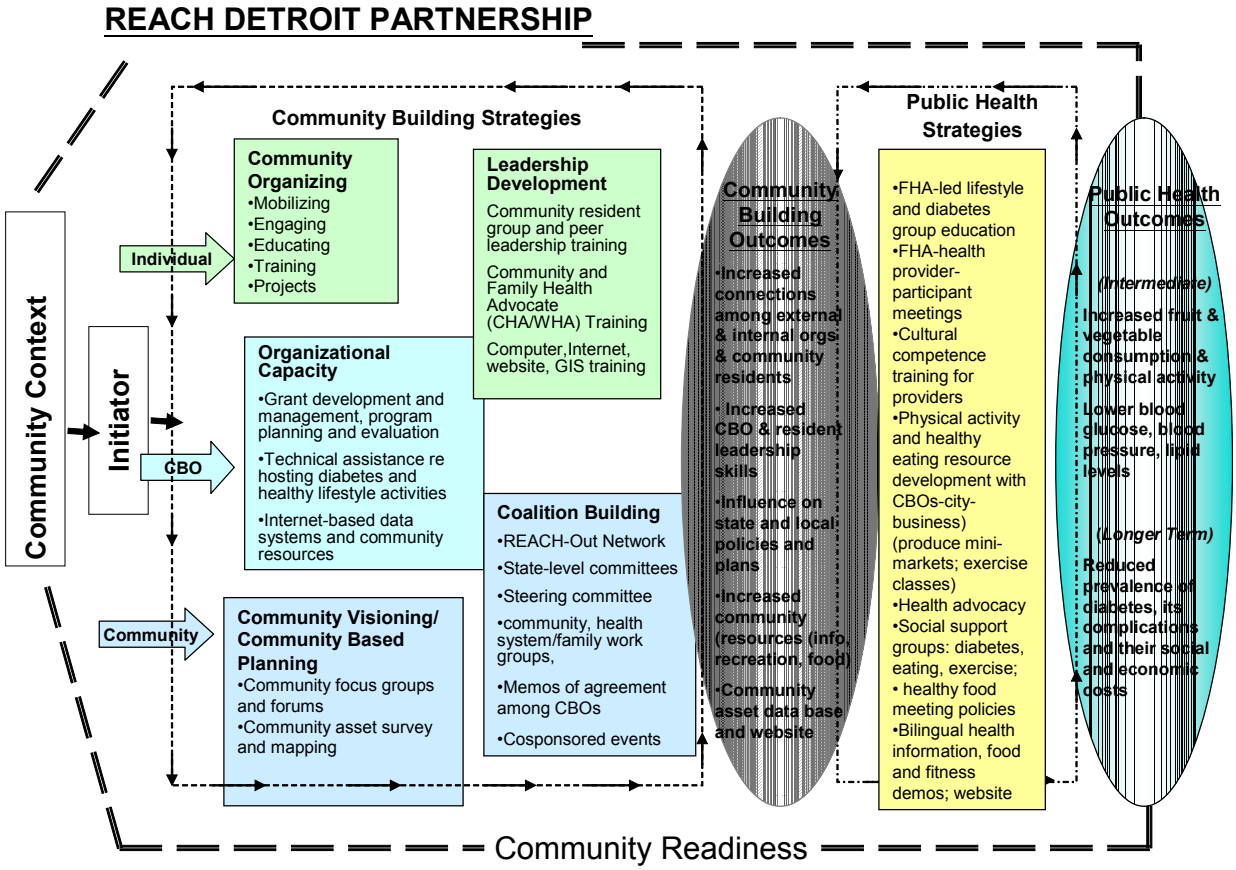
Community-building strategies may be successfully implemented, but intentional planning is required for them to result in the strong infrastructure needed to support and sustain improved public health outcomes. This requires that community building strategies be an intentional part of the public health improvement initiative. Currently, many community building initiatives that are linked to public health initiatives are short-term foundation or grant-funded demonstration projects. These projects can bring in resources and help develop skills, but without continuing access to resources, the leadership, staff, and resident capacity building activities, partnership meetings to maintain connections, and the interventions and evaluations, these activities are unlikely to continue after funding ends. Without the interventions to maintain necessary conditions for success, positive outcomes are unlikely to be sustained.

Thus, a key component of community building must be sustaining leadership and resource development long enough to identify longer term, stable funding. Funding organizations must also commit to long-term core support if efforts are to be sustained. Long-term success needs to be built on a planned framework so that changes can be institutionalized. For example, for improved capacity and community conditions to be sustained, community residents, organizations, health departments, and other governmental organizations (e.g., transportation, recreation, housing) must look at public health, community building, and program monitoring and evaluation activities as integral to their structure and core functions.

An Example of How Community Building Strategies May Achieve Improved Public Health Outcomes: The REACH Detroit Partnership

The REACH Detroit Partnership provides a case example of some of the ways in which a public health initiative that included intentional community building strategies has begun, after 5 years of continuing effort, to show positive results, both in terms of community building and public health outcomes. Figure 2 presents a model of some of these relationships.

Figure 2



In 1999, the Centers for Disease Control and Prevention (CDC) initiated the Racial and Ethnic Approaches to Community Health (REACH 2010) to support community-based interventions aimed at reducing health disparities (Giles et al., 2004). Communities were invited to submit planning grant proposals that would culminate in a Community Action Plan. These plans, while unique to each community, share a common "logic model" evaluation framework that explicitly links community building strategies to decreases in risk behavior and increases in protective behavior and, ultimately, elimination of disparities in health status. The model specifies that capacity building→ targeted actions→ change among change agents and systems

change→ public health outcomes. Because of this design, these projects should ultimately provide evidence linking community building strategies to public health outcomes.

The Steering Committee of the Detroit Community-Academic Urban Research Center (URC), a coalition of community, health care and academic organizations, formed the REACH Detroit Partnership from its members and then responded to the call for proposals. Since 1995, the Detroit URC has supported interdisciplinary, community-based participatory research that strengthens the ability of partners to develop, implement and evaluate health interventions aimed at improving the health and quality of life of families and communities in eastside and southwest Detroit (Israel et al., 2001). The URC had engaged in a wide variety of community building activities focused on increasing the capacity of its partner organizations and community residents to participate in community health assessment, collaborative planning and decision making, and increasing connections with national, state and local agencies and health professionals. Grant writing to support development of a Community Action Plan was the next step toward success.

The planning grant was awarded in Fall 1999 to URC partner, Community Health and Social Services, Inc. (CHASS), a community board-directed federally qualified health center serving southwest Detroit. The REACH Detroit Partnership Steering Committee included six community-based organizations (Butzel Family Center, Community Health and Social Services [CHASS], Friends of Parkside, Kettering Butzel Health Initiative, Latino Family Services, and Warren/Conner Development Coalition), the Detroit Health Department, Henry Ford Health System and the University of Michigan School of Public Health.

In early 2000, the REACH Detroit steering committee invited families from eastside and southwest Detroit to participate in focus groups conducted in meeting rooms of partner organizations. Participants discussed their perceptions of diabetes, high blood pressure and cardiovascular disease, health problems that had previously been identified as areas of growing community concern by community residents who participated in community surveys and focus groups as part of previous URC-affiliated projects. During this round of planning focus groups, community residents identified diabetes as having a serious and widespread impact on their families and community. They discussed their beliefs about its causes and impact, barriers to healthy eating and regular exercise, and recommendations for action. Their ideas, which were subsequently confirmed in community organization meetings with other residents, spanned societal, community, family, and individual contexts The resulting complex intervention design responded to community recommendations about how to reduce barriers to health promoting behavior and health care in their communities (Kieffer et al., 2004). Many participants said that the focus group process increased their connections to other community members facing similar challenges and helped them learn from each other about diabetes-related causes, risks and management strategies. Several volunteered to participate in the next stages of planning.

The REACH steering committee also invited work groups composed of state, city and community health, social and diabetes-related organizations and community residents to share knowledge and expertise, identify relevant literature, data and program models, host community meetings, review and interpret the planning focus group results, and make final intervention recommendations. The resulting multi-level (systems/building capacity and connections, community, social support group, family and health system) intervention aims to reduce risks

associated with diabetes and its complications among African American and Latino residents of the eastside and southwest Detroit communities. The complex design of the Community Action Plan reflects community understanding of both the barriers and their potentially solutions that is grounded in the realities of the social, cultural and physical environment Eastside and Southwest Detroit.

REACH Detroit is conducted by African American and bilingual Latino staff recruited from southwest and eastside Detroit who receive extensive training regarding diabetes and its risk factors and also in skills that build capacity and connections. Examples include community organizing, conducting community meetings and group education, peer leadership, principles of evaluation, use of computers for data collection and management, use of the internet to gain access to health information and other resources, advocacy, resource development, case management, and planning and implementing community health awareness events and media campaigns. Supervisory-level staff are also gaining skills in budgeting, personnel management, program planning and evaluation, grant writing, and developing and maintaining partnerships with state, local and community organizations.

Family Health Advocates work directly with people with diabetes, their family members and health care providers by conducting group healthy lifestyle and diabetes self-management classes based on an empowerment philosophy, and providing case management and referral services. Major intermediate and longer term health outcome objectives include increased regular exercise and healthy eating behaviors, increased diabetes self-management and improved glucose control. Community Facilitators and Community Health Advocates work to increase community level awareness of diabetes, its risk factors, and ways to reduce those risks, through media advocacy, public education and activities such as healthy cooking demonstrations. They develop and link community residents with social support resources such as diabetes support groups, walking and healthy eating groups; and community resources such as exercise classes, community gardens and fresh produce mini-markets in community organizations.

The REACH Detroit Partnership steering committee, which expanded to include the Southeast Michigan Diabetes Outreach Network, the Michigan Department of Community Health, St. John Health System and additional community-based organizations, oversees project implementation and evaluation. CHASS remains the grantee and central coordinating Organization. Members of the REACH-Out Network, an informal network of state, local and community organizations and residents, builds both community capacity and connections by providing training, helping to identify and develop resources, and to disseminate results. The project's progress, data, and evaluation findings are shared with the eastside and southwest Detroit communities through meetings, community activities, newsletters and web site: reachdetroit.org.

Examples of Outcomes

Systems Intervention – Building Capacity and Connections

Community resident members of the REACH Detroit Partnership staff now serve on state-level policy advisory committees related to prevention and control of diabetes, data and measurement, and the role of community health advocates in promoting diabetes prevention and control.

Connections and increased cooperation are evident between primarily African American-serving organizations from eastside Detroit and primarily Latino-serving organizations from southwest Detroit through successful accomplishment of project activities by the Steering Committee, intervention work groups and the REACH-Out Network. Similar cooperation is evident among the staff and among participants in the REACH family intervention.

Community and Social Support Group Interventions – Building Community Awareness, Developing Resources and Social Support Group Activities to Support Healthy Lifestyles

The Community Intervention has successfully implemented media and other public education activities designed to increase community awareness of diabetes. One of its major accomplishments is the development of a bilingual website that links community residents to accurate sources of health information and community assets for promoting physical activity and healthy eating. It is linked to a community calendar of events. This intervention has created resources that support healthy lifestyles such as salsa and hustle aerobics classes and Healthy Latino and Healthy Soul Food cooking demonstrations. It has also developed a training program to increase the knowledge and skills of community fitness instructors to address the needs of community residents with, or at risk for, diabetes. The Social Support Group Intervention has successfully trained community residents to organize and lead activities such as walking groups and diabetes support groups.

Health System Intervention

The Health System Intervention aims to improve quality and access to care provided by health care providers working with REACH participants with diabetes. Following activities such as continuing education sessions focusing on cultural competence conducted jointly with Family Health Advocates and participants with diabetes, REACH participants are reporting greater confidence in their ability to successfully communicate with their physicians.

Family Intervention

While most of the REACH interventions are aimed at building community capacity to change, the Family Intervention aims to change individual behavior and, ultimately, health outcomes. While it is too soon to expect to see changes in long term outcomes such as reductions of diabetes complications, we are beginning to see changes in intermediate behavioral risk factors and biological markers of risk for diabetes complications. After receiving social support and the "Journey to Health" curriculum from the community resident Family Health Advocates, REACH participants with diabetes have demonstrated increased levels of physical activity and fruit and vegetable consumption, and improvement in several physiological measures of health, including lower levels of blood glucose, triglyceride and blood pressure.

Factors That May Impede Progress in Establishing or Maintaining Linkages Among Community Building Strategies and Improved Public Health Outcomes

Conditions internal and external to the community may undermine the potential of community building initiatives to improve public health outcomes, if they block the development of community capacity and connections (Freudenberg, 2004). Many of these conditions are the inverse of those described previously. Most of these factors are not unique to the area of public health outcomes. Others reflect broader societal forces and the less admirable aspects of the human condition. Examples identified by interview and meeting participants included broader social forces such as "renewal" and "gentrification" that may damage or destroy longstanding community economic and social relationships; racism, sexism, inter-group, and inter-organizational conflicts; factors that impair or prevent community residents and organizations from achieving their potential for personal and professional development and obtaining the education, and economic and political power needed to achieve health and other measures of well being; competition for resources and power that are demonstrated as "turf" battles that undermine partnerships; and economic forces that limit the internal and external resources available to communities. Corrupt or self-serving leadership, dysfunctional organizational structures, forced or artificial collaborations, lack of reciprocity or trust among partners, and avoidance of confrontation when that tactic is needed may all affect the success of community building and/or public health initiatives.

Additionally, and importantly, community building efforts may be undermined if some participants in the process accrue or hold onto power or expertise and do not begin to release control of resources as community capacity increases. This is especially likely if true power in the initiative remains with outside experts who are involved in the community building process. It may also occur when community leaders or organizations gradually shift to self-serving or survival needs at the expense of community needs. This may be unintentional and even subconscious behavior, but is likely to undermine outcomes in both areas.

Why the Linkages Among Community Building Strategies and Public Health Outcomes are Not Easy to Quantify

It is difficult to find empirical evidence to confirm the relationship or the impact of the relationship on public health outcomes (Roussos & Fawcett, 2000; Kreuter & Lezin, 1998). This is true for several reasons.

- In many cases, community building strategies are part of broader public health interventions and the specific role and effect of community building strategies and activities are not often explicitly or adequately measured (Minkler et al., 2001 Dec). For too many interventions, the community building activities are seen as useful methods, but may not be seen as critical outcomes.

- In other cases, public health outcomes may be influenced positively by community building initiatives, but they are not detectable because their measurement was not included in the evaluation of the initiative, or the link was assumed but not well measured.

- Evaluation measures must be constructed and implemented that are able to assess adequately both the processes and outcomes of the community building efforts, the public health interventions and the expected changes in health-related risk and protective factors and health outcomes. Matching community building efforts to public health changes is very difficult (Kreuter & Lezin, 1998; Merzel & D'Afflitti, 2003; Roussos & Fawcett, 2000). The evaluation must capture both intentional and unintentional community building activities that occurred both as a consequence of the intervention and outside the scope of the intervention, in order to prove that a relationship between community building and public health outcomes exists.

- Some health problems result from the aggregation of risk and psychosocial and physiological damage throughout the life cycle and between generations. Thus, positive changes in behavior and environment resulting from community building efforts may take years to be evidenced by improved health outcomes. Evaluations may be more likely to detect positive outcomes for acute and some infectious health conditions and injuries than for chronic diseases. The complexity of health status and health system issues may be beyond the reach of the community building interventions. This is especially true when the underlying factors are interconnected, and when they are broad (or deep) social, economic, and political forces whose sources are based outside of the community. This situation is especially likely if the community building initiative is short term or conducted solely within the community.

- To evaluate multi-level interventions, relationships among causal processes operating within and across levels must be specified, and combinations of interventions that are synergistic across levels must be identified.

Next Steps for Better Understanding the Linkages Among Community Building Strategies and Improved Public Health Outcomes

In this paper, we have explored the contribution of community building to improved public health outcomes. Its purpose is also to make recommendations that could help to strengthen our understanding of this relationship. This section addresses recommendations for future work in this area.

- Both public health and community building practitioners must become more aware of the importance and roles of each in intervention development, implementation, and evaluation, and recognize the delicate balance between outcomes in each of the two areas. Previously, many researchers and practitioners have assumed an either/or approach to tracking and measuring results, either focusing on the public health outcomes or the community building outcomes, and have often taken a philosophical stance related to which is more important. In the future we may learn more by recognizing the potential of assuming a nonlinear interrelationship among equally important partners between the two areas, giving equal value to measuring, tracking, and documenting processes and outcomes in both areas within the same study. There are recent models for designing evaluations of community building and public health (Freudenberg, 2004); (Goodman et al., 1998), and tools for tracking community building outcomes such as Participatory

Evaluation Workbook for Community Initiatives developed by Maltrud, Polacsek, & Wallerstein (1997), and the Community Tool Box, developed by the University of Kansas (http://ctb.ku.edu). The logic model developed for the REACH 2010 projects also links evaluation of community building strategies with intermediate and longer term public health outcomes (Giles et al., 2004).

- We need to give greater consideration to assessing the impact of specific community building strategies themselves. Are some community building strategies better at producing related improvements in public health outcomes? Are some less effective? Why is this true? Under what conditions is this true?

- Given the fact that time is such a key variable in assessing both the impact of community building strategies on community building outcomes, and on the effects of these interventions on public health outcomes, policy makers and funding agencies and organizations need to provide realistic levels of support and time for expected outcomes to occur. In that context, more attention should be given to analyzing the relationship between community building outcomes and intermediate public health outcomes such as changes in health-related behavior. While documenting the next steps linking intermediate to longer term public health outcomes is also important, there are already well documented links between many intermediate outcomes and health status. For example, the recent Diabetes Prevention Program demonstrated that modest weight loss and moderate physical activity can prevent the onset of type 2 diabetes, even in high risk populations. Therefore, we should be able to measure the impact of community building strategies on changing policies, programs and the social and physical environment that support behavior changes such as regular exercise and healthful eating practices that support weight loss. These changes are more likely to be detectable within a reasonable period of time than changes in diabetes prevalence at the community level. Recently, some federal funding agencies, such as NIH and CDC, have begun to accept measures success in terms of both process measures and intermediate outcomes related to health. To include evaluation of the role of community building strategies in this process will require supporting intervention research that includes explicit methodologies for documenting and evaluating *both* community building outcomes and their impact on intermediate public health outcomes.

- Case studies that include qualitative and quantitative measures that document and evaluate both the process and outcome intervention activities may be an effective way to explore the relationship between community building strategies and public health outcomes. Additional resources should be set aside for documenting case examples that explore and illustrate the relationship. Questions about types of community building efforts, related impacts, and sequencing should be explored.

- Cost-benefit analyses comparing results of public health strategies, with and without, related community building strategies, could help to demonstrate the assumption that sustainability is not likely without the related community building strategies. Such analysis could illustrate the lost costs of investing in public health strategies without combining appropriate community building interventions.

- We need to better understand the questions of policy makers and funding organizations so that more effective cases for supporting the dual efforts of community building and public health interventions can be made.

Appendix 1

Individuals Interviewed

Kathryn Braun, DrPH, Director of the University of Hawaii Center on Aging and Professor of Public Health.

Puanani Burgess, Trainer and Consultant, Wai'anae, Hawai`i

Ho'oipo DeCambra, Legal Services for Children, Wai'anae Hawai`i

Ricardo Guzman, Executive Director, Community Health and Social Services, Detroit, Michigan

Mele Look, Director, Outreach, EXPORT Project, Native Hawaiian Health Project, John A. Burns Medical School, University of Hawai`i, Manoa

Meredith Minkler, DrPH, Professor of Health and Social Behavior, School of Public Health, University of California, Berkeley

Dr. Sharon Vitousek, Primary Care Physician, Director, Five Mountains Hawai`i,

Participants in the Facilitated Group Meeting

Alex Allen, III, Vice President Community Planning & Research
Isles, Inc., Trenton, New Jersey

Michael Bird, MSW, MPH, Executive Director, National Native American AIDS Prevention Center, Oakland, California

Nicholas Freudenberg, DrPH, Distinguished Professor of Urban Public Health, Hunter College, City University of New York

Robyn Kaufman, Executive Director, Finger Lakes Donor Recovery Network, University of Rochester, Rochester, New York

Marilyn Aguirre-Molina, EdD, Professor of Population and Family Health, Mailman School of Public Health, Columbia University, New York

Patricia Thompson-Reid, Public Health Advisor, Centers for Disease Control and Prevention and Assistant Clinical Professor, Mailman School of Public Health, Columbia University, New York

Appendix 2:`

Discussion Questions for Interviewees

1. How would you improve upon or otherwise modify the framework (diagram), assumptions and conditions (when, how and why) discussed above?

2. What data or other information (practice experience) can you share with us that supports or modifies the framework, assumptions and conditions (when, how and why) discussed above?

3. Do you know of studies or reports that explicitly assess the relationship between the two areas?

4. What additional questions would you like to see considered relative to the relationship between community building and public health strategies?

   What recommendations would you make to improve our ability to assess the linkages between community building and public health outcomes?

5. What other resource people should we talk with, or reference materials should we review?

6. What else would you like us to consider?

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