Strengthening Community Leadership: Evaluation Findings From the California Healthy Cities and Communities Program

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Abstract:

Collaborative approaches to community health improvement such as healthy cities and communities have the potential to strengthen community capacity through leadership development. The healthy cities and communities process orients existing local leadership to new community problem-solving strategies and draws out leadership abilities among residents not previously engaged in civic life. In an evaluation of the California Healthy Cities and Communities (CHCC) Program, leadership development was one of several outcomes assessed at the civic-participation level of the social ecology. Data collection methods included focus groups and surveys, semistructured interviews with coordinators and community leaders, and review of program documents. Findings suggest that the CHCC program enhanced capacity by expanding new leadership opportunities through coalition participation, program implementation, and civic leadership roles related to spin-off organizations and broader collaborative structures. Communities in rural regions were particularly successful in achieving significant leadership outcomes.

Keywords: community capacity; leadership development; community coalitions; community partnerships; evaluation

Article:

Interest in strengthening community capacity as a public health strategy has grown considerably in recent years (Dressendorfer et al., 2005; Hawe, Noort,King, & Jordens, 1997; Labonte & Laverack, 2001; Provan, Nakama, Veazie, Teufel-Shone, & Huddleston, 2003; Veazie et al., 2001). A capacity-building approach acknowledges that all communities have resources or assets that can be tapped for community building and community problem solving (McKnight & Kretzmann, 1997; Minkler & Wallerstein, 1997; Rissel & Bracht, 1999; Sharpe, Greaney, Lee, & Royce, 2000). This approach is rooted in health promotion's commitment to ground practice within the community, to strengthen the community's ability to take action, and to build on community capabilities for sustained impact (Merzel & D'Afflitti, 2003; Minkler & Wallerstein, 1997; Mittelmark, 1999).

The healthy cities and communities movement exemplifies a capacity-building approach to health promotion (Hancock, 1993; Mittelmark, 1999; Twiss, Duma, Look, Shaffer, & Watkins, 2000). Despite differences in emphasis and structure, several principles are common to healthy communities projects in the United States (Norris & Pittman, 2000; Wolff, 2003). Wolff (1992) identified three traditions on which the healthy communities movement is built: coalition building, empowerment, and community development. Each of these relies on the practices of collaborative planning, participatory learning, and engagement of local leadership (Israel, Checkoway, Schultz, & Zimmerman, 1994; Laverack & Wallerstein, 2001; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Mittelmark, 1999; Rothman, 1995). The notion is that public decision making should not be left to an elite group of elected and nonelected policy makers and bureaucrats. Rather, it should be led by grassroots individuals who craft a shared vision, frame issues, identify local resources, shape solutions, and organize themselves to improve the health of their communities.

The healthy communities process draws on existing local leadership and orients them to the task of community problem solving in new ways (Flynn, Rider, & Bailey, 1992). The process also draws out strengths in community residents who previously have not been afforded avenues to express their leadership abilities. Engaging these existing and emerging leaders through this model has significant potential to strengthen community capacity. Indeed, reports by numerous foundations have explored leadership as a keystone to community transformation and community capacity building (McNeely, Aiyetoro, & Bowsher, 2002; Pitcoff, 2004; W. K. Kellogg Foundation, 1999). In a review of several published models of community capacity, Norton and colleagues noted that leadership is critical in each (Norton, Burdine, McLeroy, Felix, & Dorsey, 2002). They emphasized the need for replenishing the pool of new leaders and the necessity of extending leadership development opportunities into traditionally underrepresented groups and cultures as communities become increasingly diverse. In a discussion of how leadership influences community capacity, Goodman and colleagues (1998) described successful leaders as people who provide direction and structure for community participation, encourage participation from diverse community networks, focus on both process and task details, and cultivate connections to other leaders.

Similar perspectives on the importance of leadership have been discussed within the literature on collaboration and coalitions (Butterfoss & Kegler, 2002; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001). Lasker, Weiss, and Miller (2001), for example, argued that effective leadership is essential to the creation of partnership synergy—the mechanism through which partnerships gain advantage over more traditional, less collaborative approaches. In their conceptualization, effective leadership contributes to synergy by creating a productive group environment, enabling meaningful participation, and engaging diverse partners. Partnership synergy, in turn, facilitates stronger relationships with the broader community, new and better strategies for solving problems, and more comprehensive and integrated solutions (Weiss, Anderson, & Lasker, 2002).

Clearly, leadership development, conceptualized as either a process or an outcome, is an important component of coalition-based health promotion models such as healthy cities and communities. Consequently, efforts should be undertaken to study it through the evaluation process. The current article presents findings related to leadership development from an evaluation of the California Healthy Cities and Communities (CHCC) Program. The CHCC Program sought to increase community capacity, in part, through the development and strengthening of community leadership. In this article, we will examine: (a) how existing and emerging community leaders were involved as leaders in local projects, (b) the extent to which new community leadership roles were created, (c) differences in the creation of leadership roles between rural and urban communities, and (d) what was learned through participation in these new leadership roles.

METHOD

Description of the CHCC Program

The CHCC Program was designed to enhance the capacity of established and emerging resident leaders to address determinants of community health (Twiss et al., 2000). Communities were selected through a competitive process in three distinct, 3-year cycles beginning in 1998 and ending in 2003. With funding from the California Endowment, 20 communities with underserved or vulnerable population groups were funded for a total of $125,000 per community. These communities were diverse in geographic location, population density, and race/ethnicity. During the 1-year planning phase, grantees were expected to develop a governance structure for a local coalition, engage a broad cross-section of the community to produce a shared vision, produce a community assessment, identify a community-improvement focus, and develop an action plan. This was followed by two project implementation years, for which objectives were developed locally based on the visioning and assessment results of the planning phase. Each of the projects employed at least a part-time coordinator to facilitate the process.

The overall evaluation of the CHCC Program was a multiple case study, with cross-case analysis (Yin, 2002). It had both process and outcome components and was guided by a framework that identified potential outcomes at multiple levels of the social ecology: individual, civic participation, organizational, inter-organizational, and community (Aronson, Norton, & Kegler, in press; Kegler, Norton, & Aronson, in press; Kegler, Twiss, & Look, 2000). The civic-participation level included the leadership-related outcomes reported here.

Data Collection Methods

Data were collected from all 20 sites using multiple methods: a self-administered, mail survey for coalition members; in-person and telephone interviews with coordinators and community leaders; focus groups with coalition members; and review of CHCC program documents.

Coalition member survey. The survey was a self-administered, 12-page mail questionnaire that was conducted at two points in time, near the end of the 1-year planning phase and again near the end of the 3-year project. The survey was issued to coalition members who had attended at least one meeting in the 6 months prior to survey administration. The surveys were tailored with the name of each community and coalition, with postcard reminders sent 2 weeks after the initial mailing and a second survey sent to nonrespondents about 1 month after the first mailing. A couple of weeks after the second mailing, up to five attempts were made by telephone to encourage nonrespondents to return the survey. Results reported here are from the end of the project period, with a response rate of 69.4% (243 of 350 surveys returned).

The survey was used to assess whether the coalition member lived in the geographic area served by the project or not and whether the member identified him or herself as representing an organization on the coalition. The survey also asked coalition members whether or not they had participated in any of 10 leadership-building activities since becoming involved in the local CHCC project. Examples of these activities include: served as an officer or chair of the coalition or one of its subcommittees; served as a representative of the coalition to other groups; presented information for your local healthy communities coalition to others; and helped to implement activities outlined in the action plan.

Program documents. Detailed 6-month and year-end progress reports were submitted to the CHCC Program throughout the project period for a total of six submissions per grantee. The report format was designed to capture the number and types of new leadership roles created in the civic life of the community. Specifically, the reports asked: (a) Were any new leadership roles created during this reporting period (task forces, chair positions, and opportunities for coordinating a significant event, taking responsibility for a portion of the work plan, etc.)? If yes, please provide details; and (b) Did a resident take on a leadership responsibility during this reporting period? If yes, please provide details on resident background and the new responsibility.

Semistructured interviews. Detailed interview guides were developed for each year of the grant period and were conducted via telephone or in person, depending on the year and designation as a primary versus secondary site (site visits were conducted in nine primary sites). Data reported here on what participants learned through their involvement are from interviews with coordinators and leaders following the planning phase ($n = 46$).

Data on new leadership opportunities were derived from a multistep process that included interviews with coordinators at the end of the project period ($n = 20$). At the conclusion of the project period for each site, all of the submitted reports were reviewed in detail and a table of new leadership opportunities was created and then reviewed through an iterative interview process with each coordinator. Coordinators were asked to distinguish new leadership roles from those that had been in place prior to their becoming a CHCC community and to identify only those roles that could be credited to the influence of the CHCC project. Furthermore, they were asked to identify only those that were anticipated to continue beyond the CHCC project period. Types of leadership opportunities included:

(a) coalition leadership roles within the governance team as well as any broader decision-making structures, (b) roles related to program implementation, (c) and other civic leadership roles, indirectly but significantly influenced by the local CHCC projects. These "other civic" roles included those related to non-CHCC collaboratives and the policy boards of spin-off organizations.

TABLE 1
Description of CHCC Coalitions and Participating Communities by Community Type

Coalition Characteristics[a]	*Total*	*Rural Region*	*Rural Municipality*	*Urban Municipality*	*Urban Neighborhood*
Number of respondents	243	88	52	72	31
Size of coalition (active members)	17.5	17.3	16.8	23.4	11.3
Mean range	6-40	6-29	10-26	9-40	9-14
Resident of community served (% yes)	63.8	86.2	51.0	52.1	48.4
Paid or volunteer (%)					
Volunteer	57.1	51.7	64.6	57.6	60.0
Part of paid duties	42.9	48.3	35.4	42.4	40.0
Representing an organization or group (% yes)	79.9	75.6	86.3	80.6	80.0
Community characteristics[b]					
Number of communities	20	7	4	5	4
Average population density	3,664	21	3,497	6,132	7,112
Average area population	35,435	15,411	27,887	64,862	41,240
Average median household income	$37,236	$36,116	$31,754	$43,059	$37,400

a. Specific to the governance groups for the local projects, in some communities larger coalitions were affiliated but not directly involved in governance of the local CHCC projects.
b. According to the 2000 U.S. Census (http://factfinder.census.gov).

Focus groups. Two focus groups were conducted in the primary sites immediately following the planning year, and one was conducted in each primary community at the end of the project period. All active coalition members were invited to participate. Data reported here are from the planning phase focus groups (17 groups, $n = 123$). Participants were asked how they benefited personally or professionally from their involvement with the CHCC project.

Data Analysis

Survey data were double entered into an EpiInfo 6 database to minimize data entry errors and then converted into SPSS Version 13 for analysis. The interviews and focus groups were audiotaped and transcribed verbatim. A detailed coding scheme was developed with coding categories corresponding to constructs in the evaluation framework (Strauss & Corbin, 1990). Two members of the evaluation team independently coded interview transcripts, resolving any discrepancies through discussion.

Survey responses and data on new leadership opportunities were grouped into four types of communities, based on population density and urban influence: rural region, rural municipality, urban municipality, and urban neighborhood. The municipality distinction was made because municipalities tend to have more centralized structures and resources than do rural regions or urban neighborhoods, and we believed that this might affect the ability of a community to influence community capacity and community change. In addition, the original healthy cities model was strongly tied to municipal structures and boundaries. High population densities characterize both types of urban communities, with urban municipalities tending to represent larger populations than urban neighborhoods because of their larger geographic areas. The two rural categories tend to be much more distinct, with the rural region communities having extremely low population densities and smaller populations than the rural municipalities.

RESULTS

Description of Coalition Members and Coalitions

Table 1 presents descriptive information on the coalitions and participating communities at the end of the project period. Coalitions ranged in size from 11.3 active members in urban neighborhoods to 23.4 active members in urban municipalities. Across all 20 communities, 63.8% of coalition members resided within the project's focal geographic area. The highest proportion of resident-participants was within the rural region communities (86.2%).

TABLE 2
Percentage of Coalition Members Participating in Various Leadership Tasks by Community Type

	Total (N = *243*)	*Rural Regions* (n = *88*)	*Rural Municipalities* (n = *52*)	*Urban Municipalities* (n = *72*)	*Urban Neighborhood* (n = *31*)
Coalition maintenance tasks					
Served as an officer	46.8	49.4	39.2	38.6	71.0
Recruited at least one new person to the coalition	55.7	54.1	51.0	62.9	51.6
Served as a representative to other groups	69.6	70.9	62.0	71.4	74.2
Presented information for coalition to others	84.8	84.9	88.2	82.6	83.9
Planning phase tasks					
Helped to develop a community vision	85.7	90.7	82.0	81.4	87.1
Helped to assess needs and/or assets	91.1	94.1	94.1	87.1	86.7
Participated in setting priorities and/or developing an action plan	89.5	91.9	88.0	85.7	93.5
Implementation phase tasks					
Helped to implement activities	85.6	85.9	84.3	84.1	90.3
Participated in evaluating progress and accomplishments	78.4	85.9	64.7	76.8	83.9
Helped to plan for sustainability	74.2	78.8	64.0	71.4	83.9

As would be expected, population density steadily increases from the most rural areas to the most urban. Area population is more variable, however, with the urban municipalities having the largest populations because the urban neighborhoods, although denser, were more spatially circumscribed. Using median household income as an indicator of socioeconomic status, urban municipalities tend to be the most affluent, whereas rural municipalities tend to be the least.

Leadership Tasks Performed by Coalition Members

Table 2 presents the percentage of coalition members reporting performance of various leadership-building tasks within their local initiatives. Involvement levels were highest for planning phase activities, such as helping to assess needs and assets. The lowest percentage reported serving as an officer or chair of their coalition. Rural municipalities reported some of the lowest participation rates by task, especially in serving as a representative to other groups and participation in evaluation.

New Community Leadership Roles

Table 3 presents the number of newly created, ongoing leadership roles developed by type of community. In contrast to the data in Table 2, these data reflect the extent to which the CHCC projects mobilized residents, well beyond a core group of decision makers, to assume prominent roles in community health improvement activities. Across all 20 communities, involvement with the CHCC Program was credited with the generation of approximately 1,100 new community leadership roles. This aggregate number, however, masks the wide variability in performance of the CHCC projects. For example, at the high end, one CHCC project generated more than 200 new leadership roles, and at the low end, another project reported only five newly created

leadership roles during the 3-year period. On average, rural region communities created more leadership opportunities than other types of communities (mean = 61.3). The mean number of new leadership roles created per community was 55.

About 40% of these new roles can be defined as coalition leadership roles directly associated with participation in the local CHCC coalitions or in broader umbrella coalitions. Although most of these were not formal coalition leadership positions (e.g., chair), in the context of a community-at-large, participation in a coalition can be viewed as a leadership development opportunity. On average, rural regions outperformed other community types in creating these types of new leadership roles (mean = 30.6). For example, several rural communities newly created crosscutting, decision-making structures to tackle community health issues that previously were narrowly addressed by categorical public agencies or else had been neglected altogether.

TABLE 3
New Leadership Roles by Community Type

Number of Roles	*All Communities (N = 20)*	*Rural Region (n = 7)*	*Rural Municipality (n = 4)*	*Urban Municipality (n = 5)*	*Urban Neighborhood (n = 4)*
Coalition leadership roles	22.1	30.6	20.5	17.2	15
Average per community					
Median	20	20	19	20	18
Range	0-93	10-93	0-44	0-25	0-24
Total	442	214	82	86	60
Program activity leadership roles					
Average per community	21.2	18.7	17.3	30	18.3
Median	19	13	16.5	24	19
Range	0-59	0-40	4-32	14-59	5-30
Total	423	131	69	150	73
Other civic leadership roles[a]					
Average per community	11.8	12	32.8	0	5
Median	0	5	0	0	0
Range	0-131	0-35	0-131	0	0-20
Total	235	84	131	0	20
Total new leadership roles					
Average per community	55	61.3	70.5	47.2	38.3
Median	51.5	55	31	47	37
Range	5-207	28-93	13-207	39-59	5-74
Total	1100	429	282	236	153

a. These figures represent leadership roles that were not directly related to the CHCC action plan but strengthened the civic and participatory life of these communities and which would not have been developed without the CHCC planning process and networking activities. They include roles related to the development of other broader coalitions or spin-off organizations. This strategy was pursued by a limited number of CHCC coalitions: 4 rural region communities, 1 urban municipality community, and 1 urban neighborhood community.

Roughly 38% of the newly generated leadership roles were related to implementation of the local CHCC action plans or to administrative support to the coalitions. These are defined as *program activity* roles. In most sites, the CHCC projects functioned not only as planning and convening bodies but also became vehicles for service delivery. Each reported *program activity* role represented a position of responsibility, often entailing management-level tasks or coordination of other volunteers. Many of these roles were highly diverse and hands-on in nature. A sampling of these roles includes café manager (an income-generating operation for the coalition), block club leader, playgroup coordinator, beautification activity leader, community garden manager, and barter services coordinator. The largest number of program activity leadership roles can be characterized as youth leadership and service opportunities. Still other roles under this classification were those instrumental in supporting the basic operations of the CHCC coalition through volunteer office management services. The urban municipalities created the largest number of program activity leadership roles.

In addition to the categories of coalition leadership and program activity roles, there was a category of new leadership roles created that were not directly related to the scope of work undertaken by the local CHCC project but which would not have come into being without it. They are classified as other civic leadership roles. Although all CHCC projects developed leader outcomes under one or both of the previously described categories, only six reported outcomes in this category, including four rural regions. These other civic leadership roles are associated with governance structures of new spin-off organizations, created in response to the issues, resources, and energies identified as part of the CHCC action planning process but not operated or sponsored by the local projects. For example, policy boards were created for new community-based organizations, like a food security agency in a remote mountain community and a family services agency aimed at the needs of Mexican Indian migrant workers in a Southern California agricultural area. In some other cases, an additional community decision-making structure was needed to address community issues in a highly focused way or on a broader geographic scale. As a result, new civic structures were created to promote community health across a region or to advance such goals as economic development, affordable housing, or recreational opportunities.

When analysis of leadership outcomes by individual site is conducted, it becomes evident that many sites chose to emphasize either coalition leadership or programmatic leadership. A total of 7 of the 20 communities developed programmatic leader roles related to their action plans; seven other communities tended to develop coalition leader roles associated with their own governance or that of a broader community decision-making body. Leadership outcomes for six communities reflected parity between these two types of new leadership opportunities.

What Existing and Emerging Leaders Learned

The evaluation design was aimed primarily at documenting outcomes, rather than the process of capacity building through leadership development, but data from documents and interviews indicate that most sites achieved leadership outcomes by providing opportunities to act and lead by doing, sometimes supported by an experienced mentor but more often by self-directed experience in the complex process of facilitating a collaborative, community-based development process. A lesser, but still notable, investment of time and resources was made in formal skill building through participation in workshops, leadership courses, and board training.

In an effort to understand how involvement in the local CHCC projects might strengthen leadership capacities, coordinators and focus group participants were asked what people had learned from being a part of the local healthy cities and communities project and how they had benefited from their involvement. One of the strongest themes to emerge was a sense of feeling empowered by the process, both as individuals and as groups. For example, a coalition member from an urban neighborhood commented, "I could say that we're change agents, we have the ability to bring about change." Involvement in the local projects also reinforced the importance of working collaboratively. A local coordinator from a rural community noted, "Together we can do a lot of things. In a group of 10 people, there's an enormous amount of skill, experience, knowledge and wisdom, and perspective that we can all benefit from."

The deepening of existing relationships and building of new relationships across people and organizations was another strong theme. For example, one coordinator noted that those involved in her community "have come to know people on a different level than what they did before." Reduced isolation and strengthened social support were highlighted by some; others focused on new or strengthened connections between organizations. Learning about the resources available through different organizations in the community, as well as their goals and programs, was also seen as useful. Lastly, many people felt that there was significant learning related to the community development and community-building process. Participants gained an understanding of an asset-based approach to community assessment, the development of a community

vision, the planning process, community-engagement strategies, and the complex nature of community change.

DISCUSSION

The creation of leadership opportunities through collaborative approaches to community health improvement is an important capacity-building outcome from healthy cities and communities programs. Leadership opportunities provide a structure through which current and emerging leaders can contribute their talents as well as enhance their skills through exposure to new ideas and perspectives. Enhanced leadership, in turn, contributes to community capacity to address current and future community priorities (Goodman et al., 1998; Labonte & Laverack, 2001; Norton et al., 2002). Leadership development was achieved as a capacity-building outcome by all of the CHCC projects, with a significant number of leadership roles established across the 20 sites. At the end of the project period, each of these roles had an established niche in the civic life of the community. Local projects stressing the development of coalition-related leadership roles, as opposed to program activity roles, were most successful in building all types of leadership opportunities.

Perhaps not so surprising, projects under the most rural category of community engaged a greater proportion of their population compared to other types of communities. What was surprising, however, was that these small and isolated communities were the most successful in developing leadership opportunities overall. The fact that the measure of comparison involves counts rather than proportions makes the achievement even more striking, especially when one considers their smaller pool of available leaders, the logistical challenges of convening them, and the limited availability of organizational resources with which isolated communities cope.

Exactly why the more remote sites performed so well is not completely clear. In reviewing the literature on collaborative leadership in rural versus urban settings, Larson, Sweeney, Christian and Olson (2002) noted that leadership development is considered more difficult in rural areas because of the dispersed population, fewer professional staff, and transportation challenges. Although these challenges were evident in the rural communities in the CHCC program, local projects were generally able to overcome them. The CHCC grant funding may have simply helped what were nascent community-building structures to expand and become more formal. Alternatively, the relative lack of organizational forums and programmatic infrastructure in these geographic areas may have reflected an unmet need that CHCC projects were in the ideal position to address.

Another observation related to the success of the rural communities is that projects with a relatively high proportion of coalition members who were residents of the focal geographic area for the project had strong leadership outcomes. In contrast, those projects with more "outside" participants generated fewer new community leader roles. Although the type of community and proportion of coalition members who reside in the community are confounded in this study, there may be an important interplay between the engagement of local residents and the extent to which capacity building through leadership development takes place.

This study is limited by the self-reported nature of the data. Although the reliability and validity of the leadership opportunity data were strengthened through triangulation of the progress reports and interviews, local coordinators were the primary source for both approaches, which may have biased the results. We attempted to limit the enumeration of specific new leadership roles to those "influenced by the local CHCC project," but interpretation of "influence" may have varied across coordinators. It is unlikely, however, that this possible bias would have differed by type of community. A related limitation stems from the challenges of attributing outcomes to a specific intervention using a multiple case study design. It may be that something other than the CHCC project led to increased leadership opportunities. We believe that this is unlikely, however, as so many of the new leadership roles were related to the coalition governance structures, generated as part of the CHCC process, and to implementation of their action plans.

CONCLUSION

Overall, our findings indicate that communities can generate significant outcomes in leadership capacity. Our findings also suggest that there is an extraordinary opportunity for civic capacity building through leadership development in highly rural areas, given a modest level of investment. Creation of leadership opportunities and engagement of residents in these roles is a critical early step in building community capacity. Participation in these opportunities, however, must expose new and emerging leaders to effective community problem-solving strategies and provide a forum in which they can learn through observation and experience to have a lasting effect on community capacity. Those participating in leadership roles in the local CHCC projects reported growth in areas consistent with capacity building, empowerment, and collaborative leadership. One of the major themes, for example, was an increased ability to bring about change—a notion consistent with empowerment (Laverack & Wallerstein, 2001; Zimmerman, 1990). Participants also spoke of strengthened social networks and new skills in visioning, assessment, and planning. Each of these is highlighted in discussions of community capacity (Goodman et al., 1998). Although not reported here, our evaluation of the CHCC program also documented significant skill improvement in a range of collaborative and community problem-solving skill areas (Kegler et al., in press).

More evaluation research is needed to develop strong methodology for assessing leadership outcomes in community-based health promotion (Barrett, Plotnikoff, Raine, & Anderson, 2005; McNeely et al., 2002; W. K. Kellogg Foundation, 1999). Although commonly mentioned as an important outcome for capacity building, discussions of the methodological issues in measuring leadership opportunities as an outcome are relatively rare. Additional evaluation research that addresses leadership development would further our understanding of how this important dimension of community capacity is strengthened through collaborative projects. Research aimed at identifying the ingredients that most significantly contribute to successful leadership development in different kinds of communities would also add to effective practice in community-based health promotion.

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