

The Healthy Communities Movement: A Time for Transformation

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The healthy cities and communities movement in the United States is less than twenty years old, yet many are ready to put the nails in the coffin and declare the movement dead. After a surge of interest in the 1980s and 1990s, the idea of creating holistic, community-based participatory approaches to improving community life is clearly in decline. But before burying the concept and the movement, it might be helpful to understand what has happened over the last two decades. What has been learned about building healthy communities and about the viability of any multisectoral, community-based approach within the context of American culture?

Have we created so many successful sustainable healthy communities that we no longer have a need for these approaches? Or did they fail so dismally that we have given up hope that such interventions can ever be effective? Or have the forces that led to the creation of healthy communities in the first place changed so dramatically that there is no longer a need for such approaches? Or were healthy communities just a health and human service fad? Or are healthy communities in the process of transformation, adapting to the twenty-first century?

Healthy Communities in America: An Overview

Healthy Cities, and later Healthy Communities, emerged from the World Health Organization, more specifically the Ottawa Charter,¹ in 1986. The Ottawa Charter moved from an individualistic view of health to a social environments and policy perspective that understood health in the context of its social determinants.² The Ottawa Charter, seen as the third public health revolution, set "capacity building for health" as its goal. In that context, the charter described the "prerequisites for health" as encompassing a very broad set of variables: "The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity."³ Extensive research on the social determinants of health laid the groundwork to link these prerequisites to health outcomes.⁴ Basic to the healthy communities approach is the "process of enabling people to increase control over and to improve their health," with *health* defined as a "resource for everyday life."⁵

Healthy communities are a radically different way of approaching health from the traditional individualistic, remedial medical services system that dominates America. The Ottawa Charter's broad definition of health opened up the possibility that communities could tackle the creation of a healthy community from avenues other than the health care system, or even Early support for the growth of the American healthy

communities movement was spread across a range of sponsors that included the World Health Organization, the United States Public Health Service and the National Civic League. The partnership of the American Healthy Communities movement with the National Civic League, an organization whose theme is "making citizen democracy work," encouraged a variety of players to enter the healthy communities arena.

The common focus of healthy community efforts was on the core concepts that defined the healthy communities process and that allowed community groups to engage in a variety of activities aimed at a broad set of variables. The core components of the process are spelled out by Norris and Howell⁶ and Wolff⁷ in these terms:

- Create a compelling vision from shared values
- Embrace a broad definition of health and well-being
- Address quality of life for everyone
- Engage diverse citizen participation and be citizen-driven
- Multisectoral membership and widespread community ownership
- Acknowledge the social determinants of health, and the interrelationship of health with other issues (housing, education, peace, equity, social justice)
- Address issues through collaborative problem solving
- Focus on systems change
- Build capacity using local assets and resources
- Measure and benchmark progress and outcomes

However, underlying these core components, there were dramatic differences in the basic assumptions that various parties brought to their healthy communities work. These differences became apparent by looking at what questions, and therefore what data, various groups used to begin their inquiries into a community. One set of players began with traditional epidemiological data on causes of death and looked to reduce the largest "killers" in their community. Thus we saw hospitals open specialized clinics for cardiac patients under the name of healthy communities. Others, inspired by the work of McGinnis and Foege⁸ on the "real causes of death," looked at the newly emerging public health issues of tobacco, diet, patterns of inactivity, alcohol, certain infections, toxic agents, firearms, sexual behavior, motor vehicles, and drug use. Thus we saw Departments of Public Health launch healthy community programs that included a range of community-based prevention activities aimed at one or more variables on McGinnis and Foege's list.

Another set of players approached their community work from a civic engagement perspective; here, the core diagnostic measure was often the Civic Index,⁹ a measure of levels of community engagement quite separate from any specific health problems. Elected officials took the leadership and focused on voter registration, leadership development, and youth asset development.

Finally, other healthy communities initiatives started with the basic premise that those most affected by the problems must be at the

core of the problem solving and definition of the issues. These community development approaches often dealt with what Chavis¹⁰ has shown are the leading concerns of grassroots residents: cash, community, and control. These last approaches were led by grassroots groups and were similar to the civic engagement approaches but had a stronger advocacy and community organizing agenda. They often tackled the issues of disenfranchised communities, such as equity, justice, power, and racism.

For over a decade, this variety of healthy city and healthy community approaches flourished in the United States. Along with various national sponsors, states began developing healthy community umbrellas that emerged out of state health departments, hospital associations, academia, and other settings. Some of the largest of these experiments came from California, Colorado, Massachusetts (Healthy Boston), Maine, South Carolina, and New Mexico, all of which were funded with state, foundation, conversion foundation, Medicaid, and money from other sources. National conferences, associations, and training programs grew as well. The concept seemed to have momentum, excitement, vision, and possibility.

It has been less than ten years since this peak, and yet the healthy communities movement is seemingly in decline. Many state associations have disappeared or reduced their activity, support, and visibility. Some, like California's Healthy Cities¹¹ program, continue, but they are in the minority. Support and funding for healthy communities have become harder to find. Over time, national sponsorship

moved from the National Civic League to the independent Coalition for Healthy Cities and Communities. When that group failed to gain funding, it became a part of the Hospital Research and Education Trust of the American Hospital Association and finally has been consolidated into Community Health Partnerships at AHA. In this last move, healthy communities have lost their independent identity as various programs were merged into this new partnership. Whether healthy communities can maintain itself as a national movement under this newest scenario is unknown.

One question that is unanswered is whether healthy community efforts have also disappeared at the local level. Mogul's¹² assessment of Healthy Boston indicated that many of the original Healthy Boston coalitions continued to survive even after the major funding dried up and the sponsoring organization (City Hall) dropped back in terms of management and support. Maybe healthy communities, like so many other true community-based efforts, is easier to support at the local level than at more centralized levels.

Our experience in Massachusetts, in addition to the Healthy Boston coalitions, confirms the view that healthy communities is a valuable concept, an extremely effective intervention when applied well, and a set of principles that make enormous sense to community residents. In Massachusetts, even communities that do not have any significant funding or staff are sustaining aspects of their healthy communities efforts because the concepts makes sense to them and because it works for them

locally. If this turns out to be true across the country, then perhaps the transformation of healthy communities will come about in part as a result of continued local community support rather than relying mostly on external support.

The Healthy Communities Massachusetts Experience

Examining almost two decades of healthy communities work in Massachusetts may help explain what has been learned and what the struggles have been. The work of Healthy Communities Massachusetts involved support of three individual coalitions, technical assistance and training for dozens of other communities, work on systems and policy change, evaluation, and trainings all across New England of those in a variety of communities movements. Massachusetts is an interesting example because of its capacity to maintain healthy community coalitions over a long period of time (almost twenty years) with limited resources and still create meaningful outcomes.

In 1984, Community Partners, a program of the University of Massachusetts Medical School, began to develop community coalitions across the Commonwealth of Massachusetts in response to the stated needs of individual communities. The first coalition began in the North Quabbin area of the state, at a bleak moment in the area's history. Once economically thriving and self-sufficient milltowns, these towns faced dire circumstances as a result of the closing of a tool manufacturing plant. Suddenly, working-class families who had never asked for help needed support, and there were not enough support services to go around.

With the help of Community Partners, the Athol Orange Health and Human Services Coalition was created to address the needs of the community. The original members were representatives of the local hospital, mental health service, legislators, residents, and the chamber of commerce. The coalition covered a nine-town area encompassing about thirty thousand people. The early years of the coalition focused on coordinating services and filling service needs. To this end, the coalition created a local information and referral service, a rural shelter for homeless families, new domestic violence prevention and treatment services, and child sexual assault prevention curricula in the schools.

After a few years, at one of the annual retreats of the coalition's steering committee, the coalition realized that to create the community they dreamed of required not only a competent helping system but also a mobilized and empowered citizenry. They renamed themselves the North Quabbin Community Coalition and worked to more vigorously engage grassroots residents and missing sectors (business, clergy, and others). At this point, the coalition's leaders learned of the healthy communities concept and started identifying themselves with the movement.

Opportunity to implement their newfound commitment to engaging the grass roots came about when, after attending one of their meetings, a foundation approached the coalition with a new funding possibility. The Boynton Foundation was impressed with the sense of collaboration, having observed the spirit of community during coalition meetings, and

dedicated all of its revenue for three years to give the coalition \$240,000 over those years to develop Valuing Our Children, a grassroots child abuse prevention program. This was in part a leadership development program aimed at training vulnerable parents to become part of the staff, board, and deliverers of preventive parenting services to other families in the community. Valuing Our Children has become a statewide model of excellence in child abuse prevention.

Grassroots residents and healthy community processes also became the backbone of the next major accomplishment for the coalition: the creation of Community Transit Services. The lack of access to public transportation had been identified as a major issue from the onset of the coalition in 1984, while task forces tackled the issue year after year without much success. Transportation seemed a difficult issue to move. Then the participants in the North Quabbin Adult Education Center, the local literacy program, became partners with the coalition and created the North Quabbin Transportation Co-Op. The group advocated with the coalition, and state and national legislators, which resulted in the first-ever transportation system throughout the area, connecting the nine towns to the major cities both to the east and west.

Advocacy for the area, and for greater statewide changes that would improve their communities, has always been a significant part of the coalition's work. The coalition has built strong relationships with local legislators and regularly advocates for new services to the area and against cuts in local services.

The North Quabbin Community Coalition continues today as a vital force in the community. The coalition sees itself as the "kitchen table"¹³ around which the various sectors of the community gather to identify and solve problems. Most recently, this has meant that the coalition has acted as the table around which to bring all the various clergy from the area towns together to focus on issues following September 11, 2001. Although the coalition budget remains well under \$100,000 per year, programs the coalition has created generate \$2.2 million and fifty-four jobs annually. The core financial support for the coalition has come from local legislators, who annually place an earmarked item in the state budget to guarantee \$50,000 for each of the three Community Partners coalitions and for Healthy Community Massachusetts, the statewide coalition.

Healthy communities became both a goal and a framework for the operations of this coalition and the parent organization, Community Partners. A healthy communities approach has transformed how the North Quabbin community does business; its commitment to this approach is deeply rooted in the community.

Three years after Community Partners started the first coalition in North Quabbin, a state representative from Cape Cod asked Community Partners to help him create a similar coalition in his area, where poverty and need were hidden by the seasonal wealth of this vacation playground. Today, the Lower Outer Cape Community Coalition covers an eight-town area with forty-five thousand people, and a mission to

improve the quality of life of those who live in the area. The coalition has developed a specific process that its task forces follow as they identify issues: identify stakeholders, define the problem, investigate options, design a response, secure resources, implement a plan, evaluate and adapt, and finally spin it off to another agency.¹⁴ It is the last step that makes this coalition's efforts different from so many others. The Lower Outer Cape Community Coalition has always seen itself as a catalyst for community change; although it has created numerous programs, they are always spun off to other community groups to own and run.

Over a fifteen-year period, this healthy community coalition has created the Interfaith Council for the Homeless, a program for homelessness prevention; the Cape Cod Children's Place, a child care center; Healthy Connections, a health access program; the Lower Outer Cape Community Development Corporation, an economic development agency; and the Ellen Jones Community Dental Center. These programs generate \$2.4 million and thirty-three jobs annually.

The Cape coalition uses the metaphor of a tree to describe itself, with roots that run deep into the community; with coalition staff, with their coordination, and gathering functions as the trunk; and with the task forces that have produced all the concrete results as the branches.¹⁵ All the branches remain connected to the tree; for example even after the Children's Place is created and spun off, the director stays on the steering committee of the coalition so that child care

issues can be integrated with whatever the next issue for the coalition may be. Thus the broad range of prerequisites outlined in the Ottawa Charter (discussed earlier) can all be dealt with under the same roof.

The third coalition, the Northern Berkshire Community Coalition, was also started by the interest of a local legislator in another area of the state devastated by a mill closing and the consequent loss of a major employer. The North Berkshire area encompasses seven towns and cities and forty thousand residents. As in the other communities, this coalition's activities were based on the stated needs of the community. The coalition developed its own unique set of programs, including working with neighborhoods, youth, and the arts. The core functions of this coalition are similar to those of the other two: large monthly meetings that convene the many sectors of the community and constitute a public place for community exchange, a monthly newsletter, and task forces that attend to the specific program priorities of the coalition.

Northern Berkshire Neighbors (NBN), a program developed by the Northern Berkshire Community Coalition, brings together neighborhood residents to discover and capitalize on the resources that exist in their community. The program contains more than a dozen neighborhood associations that engage in a range of activities, among them building playgrounds, developing crime watches, partnering with public health agencies on specific programs, providing leadership development, and creating community celebrations. Through NBN, neighborhoods have been

revitalized in the area and now form the building blocks of many communitywide efforts.

This Northern Berkshire Community Coalition has also maintained a long-standing commitment to youth development and involvement through UNITY (United Neighboring Interdependent Trusted Youth). This youth-led organization has helped spawn a coffee house, arts programming, interschool forums, and writing workshops. The coalition has also generated a set of partnerships with the local arts community that have focused on creating community, building youth development, and encouraging economic growth.

Much has been learned in almost twenty years of creating and managing these coalitions. The healthy communities process has proved to be flexible and responsive to the individual community's culture and diversity. It has been able to approach community issues from a comprehensive and ecological perspective; proved to be sustainable and durable over time; and operates at a low cost. Evaluations of the coalitions¹⁶ have shown that their outcomes include: (1) providing significant support to coalition members; (2) creating numerous community changes related to their mission as seen in changes in programs, policies, and practices; (3) reinvigorating civic engagement and increasing the sense of community; (4) creating vehicles to enhance community empowerment; and (5) becoming incubators for innovative solutions to problems facing their communities.

The work of sustaining three healthy community coalitions both fiscally and programmatically was a significant task for Community Partners, the parent organization housed at a medical school. Each coalition required intense effort to maintain a solid funding base. For example, the core legislative money that funded these coalitions required an annual process of shepherding a specific earmarked line in the budget through the state house, then the senate, then the conference committee, and past gubernatorial vetoes—just in time to start the whole process over again. Convincing more conventional state administrative agencies to adopt the coalitions remained elusive.

Programmatically, each coalition would start the year with a clear set of goals, as well as projects that usually emerged from a summer retreat of the coalition steering committee. However, shortly into the fall new issues would emerge in the community and be added to the agenda. Thus maintaining a balanced portfolio of programs that did not overwhelm the very limited staff or the energetic volunteers from the community and yet was responsive to emerging issues was a delicate dance.

Even though the success of these coalitions was impressive, directly managing more coalitions seemed unrealistic for Community Partners. However, there was a compelling need to transfer the knowledge gained in these healthy community efforts to other communities across the state and the nation. With significant support from the W. K. Kellogg Foundation, the transfer of this knowledge was undertaken in

several forms: newsletters (*Community Catalyst*, *HCM Newsletter*), tip sheets,¹⁷ books (Kaye and Wolff, *From the Ground Up*¹⁸; Berkowitz and Wolff, *The Spirit of the Coalition*¹⁹), videos ("Healthy Communities: America's Best Kept Secret," 2002²⁰), and trainings. In 1994, Healthy Communities Massachusetts (HCM) was formally created to provide a networking and training capacity for the various efforts in the state.

Community Partners decided a training institute that would provide communities with core skills was necessary to expand the movement beyond the three existing coalitions. The Healthy Communities Massachusetts Institute was developed as the key mechanism for training community teams in the core healthy community skills and principles. HCM and Community Partners graduated four classes through the institute, covering a total of twenty-one teams that represented thirty-five communities in the state. Over the years, the institute became increasingly successful at producing teams that could effectively return to their communities to implement healthy communities processes, and survive. Factors that seemed to lead to success included (1) having fewer teams in a class (four teams was best); (2) assigning a technical assistant support staff to each team that met before the trainings, worked with them through the trainings, and provided follow-up support; (3) guaranteeing that all training staff offered experiential team learning exercises; and (4) covering such core topics as the healthy community process, engagement of the grass roots, issues of social justice and diversity, the collaboration process, and evaluation.

Relative to other models of healthy communities start-ups that involve funding the collaborative, this effort was highly successful with a relatively low level of intensity of intervention and funding for the coalitions.

HCM also developed an annual conference as a gathering place for the large number of emerging community-based approaches that developed across the region. It was apparent that there were numerous groups mobilizing local communities to improve the quality of life in their communities: healthy communities; environmental groups working on sustainable communities; those creating community-based approaches within criminal justice such as reinventing justice and safe communities; those working on increasing civic engagement and exchange such as public conversations and study circles; and targeted coalitions focusing on substance abuse prevention, teen pregnancy prevention, violence prevention, and so forth. Informal exchange across these groups began to occur as they swapped resources and tools, consulted with each other, and wrote about each other in their newsletters. Thus it became possible to propose that they jointly plan healthy communities conferences throughout New England that engaged each of these groups as both presenters and participants. In spite of broad differences, HCM was able to hold two highly successful conferences, which were planned and delivered by this broad partnership from the emerging communities movement across the New England states.

As the secretary of the Massachusetts Department of Housing and Community Development said when she first visited the NQCC, "This coalition should be cloned so that we have one in every community." With that kind of endorsement, and almost twenty years of documented success, one might have expected healthy communities to become the model for communities and state government. Because this has not yet happened, we need to look at some of the challenges to healthy communities in order to understand why it has not.

@H1: The Challenges and Barriers to Building an American Healthy Communities Movement The unsolved challenges facing development of a healthy communities movement range from the terminological and conceptual to the financial and practical.

What's in a Name?

The name *healthy communities* has been a strength and a weakness for the movement from the beginning. Community movements need terms to describe both their process and their outcome, and *healthy communities* seem to fit that description. "Healthy" is often considered a positive attribute that brings to mind the images that are a part of community visions. If understood in the context of the broad definition put forth by the Ottawa Charter, it brings to mind exactly where communities are headed (peace, equity, and so on). However, healthy is often associated with health care and the disease treatment industry, which narrows associations to the term significantly. For community groups working

from a civic engagement, or a community organizing approach, the term had more drawbacks than advantages. For those working from within the health care system (hospitals and the like), the term was often deemed license to take over leadership.

The newly emerging communities movements introduce a range of other terms that describe the desirable end state of the community work: sustainable communities, livable communities, collaborative communities²¹, safe communities, and smart growth communities. Earlier literature proposed the end state as "competent community"²² and "empowered community."²³ Do any of these help in the search for an acceptable phrase that will allow so many groups to fit under one umbrella? Does such a phrase actually exist that could satisfy so many groups? Attempts to bring diverse community-based efforts together under a single organizing umbrella seem to require common language, language that is broad in scope and nondivisive. The field has yet to settle on such acceptable terms.

Core Components

The second definitional dilemma emerges from the core components of healthy communities (use a broad definition of health, and so on). Numerous authors have spelled these out, and there is usually a fair amount of agreement by authors on what the core components are. What is not clear is whether the community-based programs that called themselves healthy communities actually adhered to any or all of the agreed-upon

core components of healthy communities. In fact, it is not clear in the many descriptions of healthy communities if anyone ever asked them whether they addressed the core components. Without adherence to many or all of the core components, can we say that we have really tested the healthy communities model? A look at a few of the core components illustrates the point.

How broad was the definition of health? How many of the initiatives really wandered outside of the health care arena? Many programs that called themselves "healthy communities" kept their focus quite squarely on health, sometimes focusing on delivery and access to remedial services, and other times on a broad range of community-based public health prevention efforts aimed at reducing the incidence of specific health disorders (such as substance abuse, smoking, HIV, and so on). How many took on the less obviously health-oriented aspects of the Ottawa Charter: peace, equity, social justice, stable ecosystem, or sustainable resources?

How many of the coalitions calling themselves healthy communities actually developed a shared vision? Who was involved in that development? How diverse was participation? How often did we see those most affected by the issues at the table? How often did they hold the power? Experience with a range of healthy community coalitions would suggest that those involved were often the usual suspects from the more organized sectors of the community, not the grass roots. In Massachusetts, we did have teams bring grassroots members to our

institute, but only because we required that teams coming to our institute have at least two grassroots residents. This request was often a significant challenge for communities. Certainly, there have been excellent examples of resident engagement or even resident-driven healthy community coalitions; however, as with much coalition building in America, many of the healthy community coalitions were dominated by professionals from agencies rather than by community residents. Without residents at the table, how can the vision and the agenda be resident-driven?

Did these programs really get involved in systems change, or just program development? As Judith Kurland, the founder of Healthy Boston and one of the prime movers of healthy communities in the United States, has said, "Healthy communities is not just about projects . . . programs . . . or policies. Healthy Communities is about power. Unless we change the way power is distributed in this country, so that people in communities have the power to change the conditions of their lives . . . we will never have sustainable change."²⁴ How often did healthy community coalitions really deal with power and get involved in attempts to create larger social change? Were they involved in advocacy either within their community or at the state or federal level? Are these coalitions attempting to create what Arthur Himmelman calls collaborative betterment or collaborative empowerment²⁵?

The three Massachusetts healthy community coalitions described here incorporated advocacy and social change as part of their mission from

the start. The coalitions were engaged in a variety of local and broader issues, including efforts to bring new resources to their communities and to keep budget cuts from limiting local services. The coalitions were also allies in larger state campaigns on welfare reform and expansion of health care coverage. However, they were the exception to the rule among the other coalitions in the state. Other healthy community coalitions directly sponsored by hospitals and state agencies were considerably more cautious about engaging in advocacy activities.

Finally, how many of these coalitions actually followed the core components and evaluated their efforts and documented their outcomes? Berkowitz and Cashman, in surveying forty Massachusetts-based healthy communities programs, found that "Almost all initiatives had engaged in some form of evaluation, but such evaluation tended to be irregular, partial and nonsystematic. There may have been good reasons: lack of time, lack of knowledge, and lack of qualified outside help. But, for most initiatives, evaluation was not a priority."²⁶

Sponsorship and Funding

The most critical struggle for the healthy communities movement has been finding sponsors who can understand and endorse the healthy communities concept, manage the efforts, and provide the financial and political support. The definition of health from the Ottawa Charter allows great flexibility to the community to address whatever issue the community identifies as critical, and a fundamental principle of all

community organizing is to "start where the community is at."²⁷ However, this great breadth and flexibility of scope may have also been the downfall of healthy communities. What state, federal agency, or private foundation can provide oversight, management, or funding for a generic community initiative? If a state or federal agency or foundation has specific goals, how can it fund a generic healthy communities initiative when that initiative could end up addressing transportation, housing, violence prevention, child abuse, child care, toxic environments, or income and racial disparities?

Some few foundations have taken the path of funding comprehensive community initiatives, but even those who have call for multisectoral approaches to a single issue usually of their own choosing. Very few have funded true community development approaches. Government still struggles with wanting predictable outcomes in specific domains. Since government is structured with separate departmental programs or silos to deal with different issues through categorical funding, it has difficulty working in an integrated fashion across silos and in dealing with communities as a whole. Over the last decades, there has been considerable agreement at most levels of government that the most serious problems facing society (violence, substance abuse, HIV) cannot be solved without community involvement.²⁸ Specific issue-focused coalitions have been created and supported by government (substance abuse and teen pregnancy prevention, and others); but the broader healthy community focus that is not targeted to preordained programs has

been harder to fund. This is partly due to the more diffuse definition, and thus more unpredictable outcomes. In the Massachusetts coalitions, our greatest advantage was to have a sponsoring body that could support the communities in choosing their issues, no matter which issues they tackled. However, as noted, the major funding for this came from two sources: legislators who could see the community in a comprehensive manner more easily than agency-bound state agency personnel, and a medical school where a specific administrator was highly supportive of community development approaches to health.

Supporting healthy communities requires that government (1) understand and endorse the concept of the social determinants of health, (2) support working in a comprehensive and integrated manner across all government departments, and (3) cede power to communities for them to identify issues and implement solutions. This is a tall order in an American society that focuses more on the individual than on the community; and a society that has a service delivery system heavily slanted to individual remedial care rather than to community-based prevention. A healthy communities approach seems more compatible with the politics and economics of other governments; thus we see healthy community programs flourishing in Europe and Canada. The Canadian health care system, which is based on universal access to health care and a population health focus, creates a more hospitable climate for healthy community activities.

These challenges indicate why it was hard to find ongoing funding for healthy community strategies. However, there is also a significant issue surrounding how much funding is needed to successfully launch such efforts. In the Massachusetts Community Partners example, we attempted to stay with the concept that the healthy community coalitions were catalysts for action and that they should be funded to sustain their convening and catalyst activities. For many years, this was done for less than \$100,000 per year, and although some of these coalitions grew to actually run their own programs (in youth, arts, and other areas), their core catalyst costs remained affordable.

The Future: Healthy Communities Transformed

The need for comprehensive community-based approaches for building community capacity remains as viable today as when the healthy communities movement began. The need for health care to be addressed in a broader manner also remains unchanged. However, the winding path followed by the healthy communities movement suggests that these efforts will need to be transformed if they are to survive into the twenty-first century. This is especially true since new funders and sponsors do not seem to be on the horizon to promote healthy communities in its present form. Without that support, how will the critical processes, accomplishments, learnings, and actual spirit of healthy communities be sustained? A variety of survival options are beginning to emerge.

One future scenario being proposed emerges from commonalities that can be found across a variety of "community movements." Kesler and O'Connor²⁹ looked at seven of these movements: healthy communities, sustainable communities, community building, livable community, civic democracy, safe community, and smart growth. These programs share a similar community mobilization process but have seemingly different areas of focus (for example, growth versus safety). Kesler and O'Connor found four common content themes in these movements: a sense of community, a sense of the natural environment, a commitment to social justice, and attention to process. They also found four overlapping process themes: inclusive, ongoing value-based dialogue, use of indicators of progress, a focus on public policy, and organizational competence. Kesler and O'Connor propose one outcome: a communities movement that integrates these various approaches to create integrative visions and more sophisticated organizational capacities. However, they report that there was "not much interest among the various movements in merging their agendas and identities."³⁰ Under what conditions would these various community movements begin to see enough gain in their overlapping mission and processes to move toward integration? This remains a question.

Like Kesler and O'Connor, Potapchuk³¹ looks across a range of community-based interventions as offering the next horizon for building community in America. In this case, his scope includes efforts that give the community the capacity for deliberation, conflict resolution, and

collaboration. The specific community initiatives examined are formal negotiation processes, large-scale consensus building, participatory urban governance, community collaboratives addressing governance gaps, citizen participation, and large-scale community deliberations and community dialogues. Potapchuk focuses on the various process methods of transforming communities. He articulates the ultimate outcome as "collaborative communities" and suggests that attributes of such collaborative communities would be belief in democracy, commitment to community, meaningful inclusiveness, active citizenship, civic capacity, system and institution that work, and results. Potapchuk proposes that the various fields engaged in this work could benefit enormously if they found forums for mutual exchange on practice, knowledge building, "nurturing beacons of innovation," and building partnerships.

Lasker and Weiss³² bring a third view to creating an overarching approach that can encompass many of the emerging holistic community-based movements. They present a "multidisciplinary model that lays out the pathways by which broadly participatory processes lead to more effective community problem solving." Their theory is that the various community groups engaged in these processes essentially rely on the same community change processes. The authors suggest that when community groups begin to come to this realization, these commonalities may lead to greater cohesiveness of the efforts.

A different avenue for the survival of healthy communities emerges from the experience of single-issue coalition building efforts that

expand holistically as they develop. Most coalitions in the United States are focused on specific topics such as substance abuse prevention, teen pregnancy prevention, and violence prevention. As these coalitions engage in a deeper understanding of their "issue," they often begin to take an ecological view, which sees the impact of all the sectors and factors in the community environment on their issue. As this ecological perspective is adopted, we see examples of these topic-focused efforts expanding to a broad healthy communities viewpoint.

An excellent example of this is the sophisticated work to change a culture of violence of the National Funding Collaborative on Violence Prevention (NFCVP).³³ The NFCVP promotes the development of a safe, healthy, and peaceful nation by mobilizing community resources and leadership. The NFCVP supports strategies that emphasize resident engagement, community empowerment, and expanded national attention to the range of factors that contribute to, and prevent, violence. Within this framework, they articulate five developmental stages that communities work through to prevent violence: (1) creating safety, (2) understanding violence, (3) building community, (4) promoting peace, and finally (5) building democracy and social justice. In their conceptualization, an initiative that might start with an unsafe neighborhood closing down a crack house can end with a communitywide focus on racism and power. This is a model for other single-issue coalitions to expand to a broader healthy communities perspective as they develop. Hopefully we will see more of this in the future.

Conclusion

Recent trends in American society move us even further away from programming and funding for healthy community-type activities. With an emphasis on individuals rather than communities, with discrepancies between the haves and have nots growing dramatically, with racial and social justice sliding to the back burner, and with dramatic budget cuts at all levels, this might seem like an especially inhospitable climate for healthy communities. However, the problems that healthy communities address are not going away; we still cannot deal with the major issues facing our communities without broad community involvement. The decline in civic engagement continues to stymie the problem solvers, and the dysfunctional organization of government that focuses on categorical funding and government silos is failing to address the whole community. All of this continues to call for a solution, one driven as much by the successful process of healthy communities as by an examination of America's values and morals and a push to see the interconnectedness of all things.

As Kurland has noted: "I think there is a spirit to healthy communities that brings out what we hope our society will be and know it can be. So when people talk in spiritual terms it is about the faith and belief in what our society and democracy is about. It is this kind of spiritual uplift when we talk about what the nation could and should be—that is at the heart of healthy communities, even though we don't often

talk about it.”³⁴ The moral imperative to address the needs of our communities, to solve intractable problems, and to create social justice in the country may be what brings the nation back to a healthy communities perspective. There is a spiritual component of this work that draws on the members’ mutual values, beliefs in their community, and their ability to make their community a better place. This spirit will be part of what propels future healthy communities work.

Ultimately, healthy communities may be sustained and transformed by the communities themselves. In communities that successfully engage in healthy communities activities there is a self-reinforcing process whereby the camaraderie, support, and sense of empowerment that emerges from joint activities produces enough motivation to keep the groups engaged with each other and with the process of creating change. Lasker and Weiss³⁵ call this “synergy,” defined as “the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the complementary knowledge, skills, and resources of a group of participants.” The trend being seen of communities sustaining their healthy communities efforts on their own after the funding runs out may be based on this self-reinforcing experience of synergy. In this way, local communities themselves may become the force for sustaining and transforming healthy communities in the future. True devolution that delivers resources and power to local communities would certainly facilitate this change. In the end, it is not a question of

whether healthy communities will survive; it is more specifically a question of what form their survival will take.

Notes

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Community health centers appeared on the national scene in 1965, offering a new way of providing preventive and primary care combined with consumer involvement and cross-sectoral action to address the underlying causes of disease. Most observers gave them little chance of surviving. Jack Cradock is standing at the entrance to the health center he runs, along with medical director Jim Taylor. Since 9/11 they've made a practice of starting the day this way. It seems to remind them of why they are there and to remind the people of the neighborhood—including a sizable Arabic population—that the center is there for them. Boston, after all, is a city of neighborhoods—a tradition that Save.