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Evaluation findings on community participation in the California Healthy Cities and Communities program

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SUMMARY

As part of an evaluation of the California Healthy Cities and Communities (CHCC) program, we evaluated resident involvement, broad representation and civic engagement beyond the local CHCC initiative. The evaluation design was a case study of 20 participating communities with cross-case analysis. Data collection methods included: coalition member surveys at two points in time, semi-structured interviews with key informants, focus groups with coalition members and document review. Participating communities were diverse in terms of population density, geography and socio-demographic characteristics. Over a 3-year period, grantees developed a broad-based coalition of residents and community sectors, produced a shared vision, conducted an asset-based community assessment, identified a priority community improvement focus, developed an action plan, implemented the plan and evaluated their efforts. Local residents were engaged through coalition membership, assessment activities and implementation activities. Ten of the 20 coalitions had memberships comprised of mainly local residents in the planning phase, with 5 maintaining a high level of resident involvement in governance during the implementation phase. Ninety percent of the coalitions had six or more community sectors represented (e.g. education, faith). The majority of coalitions described at least one example of increased input into local government decision-making and at least one instance in which a resident became more actively involved in the life of their community. Findings suggest that the Healthy Cities and Communities model can be successful in facilitating community participation.

Key words: coalition; community participation; community health promotion; evaluation of Healthy Cities network

INTRODUCTION

The Healthy Cities movement was initiated by the World Health Organization in the mid-1980's as a new model of health promotion based on a broad view of health and focusing on the role of city government in 'establishing the conditions for health' (Hancock and Duhl, 1986; Hancock, 1993; Ashton, 2009). Over the next two decades, the movement spread globally to over 3000 projects worldwide, evolving to include a range of geographic boundaries and government structures (Lee, 2007). As a result, it is now often referred to as the Healthy Cities and Communities movement, particularly in the USA (Flynn, 1996; Norris and Pittman, 2000; Wolff, 2003). Healthy Cities and Communities initiatives ascribe to a common

set of principles: (i) a broad view of health, (ii) a shared vision, (iii) improving equity and quality of life, (iv) diverse resident participation and widespread community ownership, (v) a focus on systems change, (vi) development of local assets and resources and (vii) a means to measure progress and use results to make improvements (Norris and Pittman, 2000; Raphael, 2001; Wolff, 2003).

In the USA, California has been at the forefront of the Healthy Cities and Communities movement. Started in 1988, the initial California Healthy Cities project provided seed grants to municipalities to engage in a broad-based collaborative community improvement initiative (Twiss, 1997). In 1998, the California Endowment provided funding to expand the existing Healthy Cities program, at which point the project changed its name to the California Healthy Cities and Communities (CHCC) program and began to fund additional types of lead agencies, such as community-based organizations, in addition to city governments (Twiss *et al*., 2000). Currently, the statewide initiative conducts education programs for local leaders on Healthy Cities and Communities concepts, provides technical assistance and grants, and offers networking and funding opportunities through its CHCC Network.

In 1997, an evaluation framework was developed for California Healthy Cities using a participatory process (Kegler *et al*., 2000). Local coordinators were asked to list and prioritize the changes they observed in their communities as a result of engaging in the Healthy Cities process. Their responses were grouped into five levels of the social ecology: individual, civic participation, organizational, inter-organizational and community. Multiple constructs were identified within each level. From 1998 to 2003, this framework was refined and used as the basis for an evaluation of the expanded CHCC program. The current paper presents findings on key community participation outcomes, including resident involvement, broad representation and civic participation external to the initiative.

A great deal has been written in the Healthy Cities and health promotion literature about the importance of community participation (Mittelmark, 1999; Strobl and Bruce, 2000; Donchin *et al*., 2006; Minkler and Wallerstein, 2007; Foster-Fishman *et al*., 2009). Community participation is identified by the WHO as one of six key characteristics of a Healthy City (WHO, 1997). Participatory approaches such as Healthy Cities espouse the philosophy that residents have a right to self-determination, and therefore, should be involved in identifying problems and solutions that directly affect their lives (Kubisch *et al*., 2002; Fadem *et al*., 2003). Early on Dorothy Nyswander encouraged health educators to 'start where the people are' and practice in ways that are consistent with the principle of self-determination (Minkler and Wallerstein, 2003). Resident participation is believed to strengthen civic infrastructure and democracy (Blackwell and Colmenar, 2000; Kesler, 2000; O'Connor and Gates, 2000; Wolff, 2001a). Implicit in these approaches is the hypothesis that resident involvement in community decision-making leads to better policies and programs, and ultimately, to improved community health. Drawing on the tenets of empowerment theory, Foster-Fishman *et al*. states:

> Most, if not all, community-building efforts strive to encourage resident involvement in neighborhood and community affairs with the belief that through such involvement, individuals can gain personal skills and greater self-confidence, improve their relationships with their neighbors and community institutions, increase mastery over their own lives, gain a sense of power in influencing the broader community, and ultimately gain greater access to and control over resources (Foster-Fishman *et al*., 2006, p. 143).

The importance of broad representation across community sectors and socio-demographic groups is another theme common in the community participation and Healthy Cities literature (WHO, 1997; Green and Tsouros, 2008; Marks, 2009). In a recent commentary on healthy communities, Marks states that 'the future of community health action is very different from past efforts [...] an ability to work across sectors—from the usual public health and medical sectors to include education, business, city planning, and government sectors-has become more crucial' (Marks, 2009, p. 89). Lasker and Weiss posit that broader and more diverse representation leads to improved collaborative problem-solving and community health through the combining of complementary knowledge and resources from diverse perspectives (Lasker and Weiss, 2003). This collaborative problem-solving process creates a more accurate understanding of problems and their context; builds on local assets; allows for

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tailoring to local context; creates linkages across services, programs and policies and encourages concurrent action on multiple determinants of a problem. Theories of community coalitions and partnerships also emphasize diverse membership as important to achieving desired outcomes through the collaborative synergy achieved via greater pooling of resources, comprehensive assessment and planning, and multilevel interventions grounded in community context (Lasker *et al*., 2001; Butterfoss and Kegler, 2002).

Intersectoral collaboration and community participation have been documented in numerous Healthy Cities initiatives (Connor *et al*., 1999; Strobl and Bruce, 2000; Harpham *et al*., 2001). Connor *et al*., for example, examined the breadth of citizen involvement in the Colorado Healthy Cities and Communities initiative by assessing the number of citizens involved, demographic and sector representation, how well the governance groups reflected their communities and the involvement of 'new' sectors, such as business, environment and transportation, compared with 'traditional' sectors that typically work on health promotion projects (Connor *et al*., 1999). Donchin *et al*. surveyed Healthy Cities coordinators in Israel to examine implementation of key Healthy Cities principles, including community participation and intersectoral partnerships (Donchin *et al*., 2006). To assess community participation in Healthy Cities projects in four developing countries, Harpham *et al*. examined the extent of involvement by key stakeholders, women and city leadership (Harpham *et al*., 2001). More recently, the WHO European Healthy Cities Network conducted an evaluation that documented community participation and intersectoral collaboration through annual reports, a questionnaire completed by Healthy Cities coordinators with approval from a local policy official and a series of case studies (Green and Tsouros, 2008). Community participation was categorized into four types: information, consultation, participation and empowerment (Davidson, 1998).

An important but less often studied attribute of community participation is the possibility of sparking civic engagement in community life beyond a specific initiative. The community empowerment literature suggests this possibility as an important outcome, as did the California Healthy Cities coordinators who participated in development of the evaluation framework described above (Kegler *et al*., 2000; Becker *et al*., 2002). However, attempts to document whether participation in community problem-solving initiatives such as Healthy Cities can lead to increased civic engagement are relatively uncommon (Swaroop and Morenoff, 2006; Berry *et al*., 2007; Larson and Manderson, 2009).

The current paper presents selected community participation findings from an evaluation of the CHCC program (Kegler *et al*., 2003). Specific evaluation aims included assessing the ways in which the local CHCC initiatives: (i) engage residents, (ii) achieve broad representation and (iii) facilitate civic engagement. We also examined factors that facilitated and inhibited these dimensions of community participation. By using a mixed-methods design, we were able to examine both the breadth and depth of community participation in CHCC.

METHODS

Description of the CHCC program

In 1998, the Public Health Institute's Center for Civic Partnerships received funding from the California Endowment to expand its existing Healthy Cities program to 20 additional communities in three phases (Twiss *et al*., 2000). Participating communities were selected through a competitive process and were awarded a total of $125 000 over a 3-year period. Communities were diverse in population size (1200–130 000 residents), population density (1.0–12 141 persons per square mile) and socio-demographic characteristics. They were also diverse in terms of geography, ranging from remote mountain regions to urban neighborhoods in major metropolitan areas. Both private, non-profit (501c-3) organizations and government entities, including city and county governments, served as fiscal sponsors.

During the initial planning year, each grantee developed a broad-based and multisectoral governance structure termed coalition here. Grantees were asked to involve a broad cross section of residents and community partners in positions to influence the key determinants of health such as education and living conditions. The tasks for year one were to produce a shared vision, conduct an asset-based community assessment, identify a high-priority community improvement focus and develop an action plan

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with goals, objectives and an evaluation plan. The subsequent 2 years were spent implementing their action plans for community health improvement and planning for sustainability. Priority areas selected by the coalitions included: youth development, civic capacity-building, neighborhood improvement, lifelong learning and economic development, among others.

Data collection methods

The evaluation design was a multiple case study with cross-case analysis (Yin, 2003). Nine of the 20 sites were designated as primary evaluation sites (initially three per funding cycle) and participated in more extensive data collection activities, including site visits and focus groups. These primary sites were identified to represent a wide range of geographic locations and sponsorship arrangements. Data were collected from all 20 sites using multiple methods.

Coalition member survey

The survey was a 12-page, self-administered mail questionnaire that was completed by active coalition members near the end of the 1-year planning phase and again near the end of the project period. 'Active' was defined as attending at least one meeting within the past 6 months. Members of youth groups and youth advisory councils were generally not surveyed. The overall response rate across both years was 70.0%, with 330 out of 469 (70.4%) surveys returned in the planning phase and 243 of 350 (69.4%) returned in the implementation phase.

Key informant interviews

Detailed interview guides were developed for each year of the 3-year grant period with interviews conducted via telephone or in-person, depending on the year and designation as a primary versus secondary site. Respondents fell into five general categories: coordinators, other project staff, community leaders, fiscal sponsors and CHCC program staff. A total of 165 in-depth interviews were conducted.

Focus groups

Three focus groups were conducted with active coalition members in the primary sites over the course of the evaluation, two in the planning year and one at the end of the project period (26 focus groups, $n = 176$).

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 information relevant to the constructs in the evaluation framework.

Measures

Briefly, we assessed the number of residents through both the coalition member survey and progress reports. Progress report numbers were confirmed through interviews with the local coordinators. How residents were involved in the initiative was assessed through three data collection mechanisms: progress reports, interviews and focus groups. Sector representation was also assessed through both the survey data and interviews. Factors that influenced community participation were identified through interviews and focus groups. Civic engagement, including increased participation in community life and expanded input into government decision-making were assessed through interviews with coordinators.

Data analysis

Survey data were double entered into an EpiInfo 6 database to minimize data entry errors and then converted into SPSS Version 15 for analysis. The interviews and focus groups were tape-recorded and transcribed verbatim. With very few exceptions, each interview and focus group transcript was independently coded by two members of the evaluation team. Discrepancies in coding were resolved through discussion. Text retrievals on specific codes or combination of codes were completed using the qualitative data analysis software package QSR-N6. Additional in-depth content analysis was then performed on these text retrievals to identify major themes (Patton, 2002).

RESULTS

Resident involvement

We used the coalition member survey to document the percentage of adult coalition members who lived in the area served by their coalition. Table 1 shows that membership in half of the

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Table 1: Number and percentage of CHCC coalitions with various levels of resident involvement

Percent of coalition members who live in area served by coalition	CHCC coalitions [*n* (%)], n = 20	
	Planning phase	Implementation phase
0–25	2 (10.0)	1 (5.0)
26–50	2 (10.0)	4 (20.0)
51–75	6 (30.0)	10 (50.0)
76–100	10 (50.0)	5 (25.0)

coalitions comprised >75% residents in the planning phase, with variation from 15.8% to 100% across individual coalitions. Overall, resident composition of coalitions decreased somewhat in the implementation phase. Nonetheless, three-quarters of the coalitions maintained a majority (at least 50%) resident composition during the implementation phase. Qualitative data suggest that the decrease may be due to a narrowing of focus from assessment and visioning to implementation of a specific action plan to address the selected priorities. Interestingly, local residents represented 100% of the governance board members for 3 of the 20 coalitions during both the planning and implementation phases. Each of these was a rural community with a low population density (<50 persons per square mile). Qualitative data indicated that sites with greater resident involvement in governance structures tended to have more than one collaborative structure, as well as a youth advisory group.

Most of the residents on the coalitions reported that they represented not only community resident interests but also a community sector. However, all but one coalition had at least one member who felt they 'best represented' an interested resident (Table 2). Of these, 11.8% were African American, 15.7% were Hispanic, 5.9% were Asian/Pacific Islander and 60.8% were White. A wide range of ages and education levels were represented on the coalitions, with 17.6% under age 25 and 21.2% reporting a high-school degree or less. The majority of those participating solely as an interested resident were women (71.4%).

We also wanted to understand the various ways in which residents were involved in the CHCC initiative. As part of the interviews and focus groups, respondents were asked to describe opportunities for residents to provide input into their local initiative. Respondents most commonly described their coalitions and associated committees as a significant mechanism for resident input. A second major mechanism for resident involvement was the community assessment process, and to a lesser extent, the visioning activities completed during the planning phase. In particular, survey participation, a common data collection strategy used by coalitions during the assessment process, was viewed as a major opportunity for resident input. Community forums, dialogues and focus groups were other vehicles for resident involvement. Most commonly, resident participation involved completing surveys or attending community meetings, but in a few sites residents were actively engaged in data collection by facilitating focus groups or conducting door-to-door surveys themselves.

Implementation activities provided a third significant mechanism for resident involvement. Sites with large numbers of residents involved in implementation conducted community mobilization events, such as neighborhood clean-ups, time exchange programs and civic education programs, many of which generated spin-off activities. Sites having more limited resident involvement during this phase of the project tended to operate staff-run programs.

Table 2: Description of community sector involvement in CHCC coalitions, planning phase

Number of community sectors involved	Number and percent of coalitions [*n* (%)] *n* = 20
0–5	2 (10.0)
6–10	10 (50.0)
11+	8 (40.0)
Sector	
Education	20 (100.0)
Resident	19 (95.0)
Community-based organizations	17 (85.0)
Social/human services	16 (80.0)
Other	16 (80.0)
Faith	14 (70.0)
Health care	14 (70.0)
Public health	11 (55.0)
Criminal justice/safety	11 (55.0)
Recreation	11 (55.0)
Political/elected officials	10 (50.0)
Business	9 (45.0)
Housing	7 (35.0)
Neighborhood or civic group	7 (35.0)
Media	2 (10.0)

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Coordinators and community leaders were asked to describe the factors that facilitated and inhibited resident involvement (Table 3). The most commonly mentioned barrier was a lack of time due to competing family and work demands, and the related complication of finding an appropriate time to meet when some people participated as part of their jobs and others did not. Language and transportation barriers were also mentioned quite often. Even when translation services were used, language differences were seen as an inhibitor, contributing to long and cumbersome meetings. Transportation issues were highlighted most often in the context of rural communities with distance, terrain and mass transportation challenges, inhibiting participation for all, but especially for youth who could not yet drive or did not have access to a car. A lack of familiarity with community or coalition meetings (e.g. meeting procedures, unfamiliar jargon) was also mentioned as a barrier. One site established a separate committee for grassroots residents, with the meetings conducted completely in Spanish and a translator for the staff. Additional barriers mentioned included a lack of personal benefits for involvement and the desire for action over process.

The most commonly mentioned facilitating factor was creating a welcoming environment for newcomers. This involved holding meetings at times convenient for residents, providing transportation, making telephone calls and following-up with people before and after they attended a meeting or event. Another theme was that well-connected coordinators and volunteers who had existing relationships with diverse parts of the community were integral to success in fostering resident participation. Distributing information about the initiative widely through media, newsletters and word-of-mouth was another facilitating factor, as was partnering

Table 3: Major factors that influenced resident involvement

Major themes	Illustrative quotes
Facilitating factors	
A welcoming environment for newcomers	*We started to actually pick up people in our own cars . . . because people just didn't want to come in alone.*
Well-connected coordinators and volunteers	*The key has been the volunteers themselves were a group of people that come from various parts of our community and were able to tap in and actually meet with the people in different groups to give them the opportunity* (to get involved).
Widespread promotion of the initiative	*We'd get front page coverage and people started to know this was a real thing.*
Partnering with trusted organizations	*It would be hard for instance to get representatives of grassroots people from the Latino community if we didn't go through an agency. It's very interesting especially in our community where certain organizations just seem to have a lot of influence on people and I guess the folks have confidence in what they're about.*
Commitment to an inclusive process	*I worked on a lot of people, and a real determination to make sure that at that stage, everyone was invited, that this was the most inclusive thing that's ever been done, and that everybody felt like their opinion was important.*
Inhibiting factors	
Competing work and family demands	*People are so caught up in survival that it might be hard to step outside the day to day demands of just making sure you have enough to take care of yourself, to participate in a larger process that takes your time, but doesn't really present any immediate, tangible rewards that would impact your daily living needs.*
Language differences	*Language. The meetings are in English. We go back and forth in the general meetings, but it's cumbersome and challenging for everybody. We do have the translation equipment, and they make that available every time, but it's still a challenge.*
Transportation challenges	*I think there were some kids that didn't come because maybe their parents couldn't pick them up, and that was the other . . . transportation is a big issue.*
Intimidated by coalition meetings	*You can't reach out to people who have never been part of an organizational process . . . try sitting in an organizational meeting sometime and listen to some of the words that we use. You can't even translate them into Spanish, much less explain what they mean. People, without skills and training, are not able to sit in a process like this and participate. So, they just don't show up.*
Residents prefer action over process	*[our meetings] really deal with a lot of process, I mean I've got to tell you, there's not many grassroots people that like to come to meetings to deal with process. But they like to be involved . . . where they are digging their teeth into something meaty.*

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with trusted organizations. Commitment to an inclusive community development process by coalition leadership was also viewed as an important factor. Additional themes included providing activities where residents could see quick results, structuring meetings to ensure that everyone could be heard, making an effort to get to know people in the community and providing mini-grants for local groups to address their own needs.

Broad representation

Multiple dimensions of representation can be assessed, including engagement of traditionally underrepresented segments of the community and broad involvement across community sectors. To measure the former, we asked coalition members and coordinators to consider the diversity of their communities and comment on how satisfied they were with the demographic representation they had been able to achieve. About half of the coalitions felt that they had made some progress but their efforts were still insufficient. Challenges associated with engaging the Hispanic population were mentioned most frequently. Interestingly, respondents from several coalitions expressed satisfaction with the diversity of participants in the programs they conducted and with the diversity of the youth group members, but were struggling to engage diverse adult leaders and coalition members. Close to half of the coalitions were generally satisfied with the demographic representation achieved. The sites reporting greatest satisfaction noted strong relationships, partnerships and geographic convenience as facilitating factors. Other notable methods of garnering diversity included creating a warm atmosphere, giving people a voice and a strong commitment to diverse participation. The remaining few communities felt that their efforts were not successful, mainly attributable to geographical, socio-economic and language barriers.

Intersectoral collaboration was a major goal of the CHCC process, and coalitions achieved substantial progress in fostering working relationships across community sectors. Education, community-based organizations and social/human services were the best represented sectors on the coalitions (Table 2); housing, neighborhood and civic groups and the media were the least represented, as measured through the coalition member survey. Fifty percent of the coalitions had 6–10 sectors represented during the planning phase, and 40% had more than 10 sectors represented (Table 2). Qualitative data revealed two primary forms of collaboration across sectors: membership on the CHCC coalition or strategic partnering to operate a program, deliver a service or advocate for a specific cause.

Coordinators and coalition members were asked to comment on the factors that facilitated or inhibited their ability to develop new partnerships and foster intersectoral collaboration. The most commonly mentioned facilitating factors were persistent, talented and hardworking staff and leaders, an inclusive and interactive planning process and identification of the right issue in terms of mutual interests across sectors and/or timing, or in other words, opportunistic flexibility. Other facilitating factors included building on existing networks of key individual and organizational players in the coalition, the positive reputation and early successes of the CHCC coalition, funding for infrastructure including staff persons who could devote time to the partnerships and mutual dependence and related advantages of collaboration.

Reported barriers to intersectoral collaboration included people being too busy to devote time to create new relationships, a geographically dispersed population, economic or political fragmentation and territoriality. Additionally, it was sometimes hard for representatives of diverse sectors to identify shared interests. Respondents from rural areas reported that some traditional community sectors simply did not exist, such as the housing sector. Lastly, coordinator time, staff turnover and limited funding were seen as barriers to intersectoral collaboration.

Civic engagement external to the initiative

We examined whether residents increased their engagement in the life of their communities as a result of their participation in the local CHCC initiatives. Coordinators and leaders were asked to share stories of people empowered to become more civically engaged as a direct consequence of their involvement with CHCC. Most of the site coordinators were able to share at least one such story. Examples included CHCC participants establishing a rural

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volunteer fire department, building a community playground, writing grant proposals for other community improvement efforts, volunteering as a neighborhood block captain, coaching youth sports teams, volunteering with a youth poetry literacy program and joining the local Parent–Teachers Association.

Coordinators and community leaders were also asked about the development of new opportunities for residents to provide greater input into the decisions of local government. The majority of coalitions were able to provide at least one example of increased input into government decision-making. Respondents most frequently mentioned the appointment of the coordinator, or others involved with the local project, to a local government advisory group such as a rural health board, a county parks and recreation committee or school committees. The second most common response was the mention of coalition member attendance at government meetings, such as school board, planning commission and city council meetings. A few of those interviewed spoke of how their projects had either groomed or encouraged someone to serve on a city commission or run for city council. Finally, some coordinators described how members established new partnerships to advocate for the needs of neglected neighborhoods or communities with county or city officials. Concrete successes included keeping a rural school open in the face of severe district budget cuts, convincing a local government to purchase and lease a building under a no interest/purchase option for a new youth center, persuading the county to appoint a citizen task force to examine affordable housing issues, and pressuring school officials to increase capital investments in a neglected inner city neighborhood, along with the naming of a new school after a respected community leader, to list a few.

DISCUSSION

This paper examines several dimensions of community participation within the context of the CHCC program, including resident involvement, broad representation and civic engagement. Overall the CHCC coalitions were successful in engaging residents, either as coalition members, as participants in a community assessment or as leaders or participants in the coalition's implementation activities. Sites that had a more complex collaborative structure, as with multiple task forces and/or a youth advisory group, reported the largest number of residents involved in governance of the initiative. Sites that focused on community mobilization efforts such as neighborhood clean-ups or civic education programs, which typically generated multiple spin-off activities, had larger numbers of residents participating during the implementation phase compared with sites that focused on staff-run programs. Common barriers to involving residents were lack of time due to competing family and work demands, language differences and transportation difficulties. Concerted efforts to create a welcoming environment, such as offering to accompany people to the meetings, facilitated resident involvement, as did well-connected coordinators and the involvement of trusted community organizations.

Results also indicate that the CHCC coalitions were successful in achieving broad community sector representation, with almost all of the coalitions engaging representatives of six or more sectors during the planning phase. Our findings that the education and social service sectors are more readily engaged than other sectors such as media or business are consistent with findings from other Healthy Cities evaluations (Connor *et al*., 1999; Green and Tsouros, 2008). Other studies have found that greater diversity in sector representation is associated with action plan quality, number of activities implemented and policy change (Kegler *et al*., 1998; Hays *et al*., 2000). Although coalition theory suggests diversity in membership should contribute to health and social outcomes, a longer study period would be needed to observe these relationships (Butterfoss and Kegler, 2002; Lasker and Weiss, 2003).

Over 10 coalitions felt that they made progress toward, or were satisfied with, their demographic representation citing strong relationships, partnerships and geographic convenience as facilitating factors. Research linking demographic diversity of coalitions to outcomes is limited, but one study reported associations between demographic diversity and impact on local prevention systems and policy, as measured through coalition member perceptions (Hays *et al*., 2000).

This study documents that participation in a community building initiative can lead to

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greater civic engagement and the development of new opportunities for resident input into local government decision-making. In some communities, the coordinator or others involved with the local project were appointed to an advisory group for a local government or social service agency and in other sites residents attended school board, planning commission and city council meetings. A related important outcome of the CHCC program was empowering residents to increase their involvement in the civic life of their communities. In a recent study by Foster-Fishman *et al*., residents with organizing skills and perceived norms for activism were found to predict participation in neighborhood and community affairs (Foster-Fishman *et al*., 2009). Although not tested in our evaluation *per se*, similar mechanisms may have facilitated increased community participation in the CHCC communities. A separate analysis of our evaluation data showed that increased skills in community problem-solving and collaboration were correlated with higher levels of participation among coalition members (Kegler *et al*., 2007).

Several questions emerged in our attempt to measure community participation and interpret our results. How should the *number* of residents involved relative to the *level* of involvement be balanced? Is the objective to engage a large proportion of community residents or to engage a small number in meaningful governance of the initiative? Is it important to maintain a high level of resident participation through all phases of an initiative? Tritter and McCallum (Tritter and McCallum, 2006) note the tension between 'involving some people intensively and involving many people in a limited way'. For example, one site may have involved hundreds of residents in a neighborhood beautification effort and another might have involved a handful very deeply in designing and managing an after-school program. Engaging a large proportion of any reasonably sized community in governance is not logistically feasible, leaving community assessment and program implementation-related participation as the primary mechanisms for engaging large numbers of residents. Kubisch *et al*. note that in many community improvement initiatives, the numbers of residents involved is small and that a 'continuous investment by residents may not be necessary all the time, especially in the more technical or operational aspects of an initiative' (Kubisch *et al*., 2002). They also note that the level and intensity of resident involvement varies over time and that certain phases are typically more staff-driven than other phases.

Second, we struggled with how much emphasis to place on the engagement of *grassroots* residents. A fair amount has been written in the health promotion literature about engaging grassroots residents in community health improvement efforts (Baum *et al*., 1997; Chavis, 2001; Kaye, 2001; Wolff, 2001b, 2003; Kubisch *et al*., 2002). Several of our measures attempted to distinguish between grassroots residents and residents with a professional affiliation such as school principal or social service provider. Interestingly, most survey respondents who lived in the community being served by the CHCC project and who identified their affiliation with a community sector or with a specific agency often felt that they were participating in the CHCC coalition primarily *as a resident*, not as a professional. This was particularly true in the most rural communities. These 'resident professionals' saw themselves as parents, neighbors, patients, customers and simply as citizens, and these roles appear to have trumped their work roles as motivating their participation impulses. They often wore their 'resident hat' in addressing general issues under consideration by the coalition but switched to their 'professional hat' when topics touched on the organizational or community sector interests they represented. This is not to imply that resident professionals can, or should, serve as substitutes for grassroots resident participation but rather to acknowledge the resident perspective contributed by many professional members of coalitions. Moreover, different types of community initiatives may necessitate different types of resident involvement. For example, locality development projects may exclusively focus on neighborhood organizing and informal leadership development, whereas Healthy Cities efforts, which aim to change social determinants of health, require substantive representation from a wide range of community sectors that influence the health-related resources and policies.

The major limitation of this study is that all data are self-reported from individuals heavily involved in the local CHCC initiatives. Given that coordinators and coalition members were familiar with the principles of the Healthy Cities movement, they may have given socially desirable responses about resident involvement and broad representation. Triangulation of data

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sources within sites and consistency of themes across sites, however, suggests that this was not a major problem. A second limitation stems from heavy reliance on the coalition member survey for assessing representation. This may have contributed to an under-reporting or misrepresentation of resident and sector involvement. Survey non-respondents may have differed in important ways from respondents, perhaps disproportionately representing grassroots participants, for example. Further, members of most of the youth advisory groups, all of whom were residents, were not consistently surveyed.

Our study has numerous implications for practitioners and researchers attempting to promote community participation. Both the factors that facilitate and the barriers that inhibit resident involvement and broad representation require concerted and focused effort to address, in combination with community organizing skills. Creating a welcoming environment, establishing partnerships with trusted community organizations and ensuring an inclusive community development process require substantial commitment of human capital and other resources for outreach, bilingual staff and materials, incentives, training and technical assistance, multiple meeting locations and varying types of participation (Kaye, 2001; Kubisch *et al*., 2002). To the extent that distrust stemming from a history of discrimination and racism limits participation, racism training in the development of collaborative teams may also be helpful (Yonas *et al*., 2006; Aronson *et al*., 2008). Unfortunately, current funding levels for most community improvement initiatives are insufficient to provide the infrastructure and support necessary to generate extensive resident involvement, while simultaneously implementing a planning and implementation agenda. This issue bears serious consideration by health improvement practitioners and funders as they strive to engage the full spectrum of community members in successful community building initiatives.

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