Community Coalition Action Theory as a Framework for Partnership Development

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Introduction

As an action oriented partnership, a coalition usually focuses on preventing or ameliorating a community problem by analyzing the problem; gathering data and assessing need; developing an action plan with identified solutions; implementing solutions; achieving outcomes; and creating social change (Butterfoss & Kegler, 2002).

CCAT is one of only a few comprehensive coalition theories posed in the literature that comprehensively addresses coalition building. This theory was developed by Butterfoss and Kegler (2002) based on decades of literature, wisdom knowledge, and the personal experiences and expertise of the authors.

CCAT authors see community coalitions as a specific type of coalition and subscribe to the definition of community coalition presented by Feighery and Rogers in 1990 as "a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal" (Butterfoss & Kegler, 2002).

CCAT is comprised of fourteen major constructs. Twenty-three practice-proven propositions relate to the various constructs. Each of these constructs and the literature that relates to them will be addressed in the following sections. The CCAT constructs and propositions provide an underlying framework for understanding the processes, structures, and outcomes experienced by effective community coalitions. The literature supports these constructs and further extends the knowledge about what makes coalitions effective in addressing intermediate and long-term health outcomes.

Dr. Francis Butterfoss, one of the CCAT authors, believes the CCAT theoretical framework can be applied to statewide coalition building efforts (Butterfoss, 2008). The framework should provide a roadmap for building an effective coalition and will provide a basis for evaluating coalition effectiveness.

Model Constructs and Propositions

Construct 1: Stages of Development

The first proposition states that coalition building is cyclical, cycling through three stages of development based upon situation and need: stage one – formation, stage two – maintenance, and stage three - institutionalization. While researchers vary on the names and stages, all agree that common activities occur over the lifespan of a coalition, including recruiting, mobilizing members, establishing organizational structure, building capacity, planning for action, implementation of strategies, evaluating outcomes, and institutionalizing strategies (Butterfoss & Kegler, 2002).

The second proposition under this construct states that at each stage, specific factors enhance coalition function and progression to the next stage. The model details these factors, which are well supported in the literature and reviewed here.

Coalition Formation

During coalition formation, a convener or lead agency brings together a core group of organizations that will then recruit the initial members. Leaders and staff are identified and structural elements such as committees, rules, and operating procedures are developed (Butterfoss & Kegler, 2002). At this point, participation is enhanced when members feel benefits of participation outweigh costs (Butterfoss and Kegler, 2002; Rogers, et al, 1993).

Key factors in the formation stage include resources exchanged by potential members that lead to inter-organizational cooperation; payoffs for coalition members; and adequate size of a core group (Butterfoss and Kegler, 2002). Articulation of a clear mission or guiding purpose seems to be a key element of successful formation (Butterfoss et al, 1993).

Butterfoss, Lachance, & Orians (2006) used a multi-method examination of three coalitions to describe how coalition formation was influenced by community context, history, leadership, membership, structure, processes, and other factors. Study results noted the influence that contextual factors such as trust, politics, history of collaboration, geography, and community readiness can have on successful coalition formation. Leadership characteristics found to be important to formation include a strong administrative and management infrastructure, existing community relationships, and understanding and support for coalition efforts. Effective structural characteristics were found to be formalized rules, roles, structures, and procedures. These might include steering committees, subcommittees, rules of operation, by laws, policy statements, mission statements, written goals and objectives, regular meetings with agendas, and a clear communication pathway.

The core members of a coalition were found to be key to initial success. Experience was an important member characteristic as were commitment, diversity, and lack of conflict. Increasing community participation early will decrease conflict and improve later implementation (Roussos & Fawcett (2000).

Leadership competence and staff competence were found to be associated with intermediate outcomes. Coalition processes such as frequent, productive communication, member influence in decision-making, and conflict resolution were seen as facilitating factors for intermediate outcome achievement.

Coalition Maintenance

During coalition maintenance, determinants of success include sustaining member involvement and recruiting new members, implementing competent processes and concrete action, acquiring member and external resources, and identifying positive results (Butterfoss and Kegler, 2002). Coalition building and maintenance require time and member commitment (Wynn, Johnson, Fouad, Holt, Scarinci, Nagy, Partridge, Dignan, Person, & Parham, 2006).

Butterfoss et al (1993) identify factors contributing to implementation and maintenance including degree of formality, leader and member characteristics, organizational climate, and relationships with external supports. Several additional factors have been shown to facilitate implementation, operationalized as the number of activities completed, including: coalition vision, skilled staff with adequate time to work on coalition activities, frequent and productive communication, cohesion or sense of belonging, and complexity of coalition structure such as the presence of task forces or subcommittees (Kegler, Steckler, Malek, & McLeroy, 1998). Barriers to successful implementation included staff turnover, staff lacking community organization skills, dependence on state-level staff during planning, and lack of member input into action plan (Kegler, Steckler, Malek, & McLeroy, 1998).

A model of coalition development, proposed by Kegler, Steckler, McLeroy, & Malek (1998) identified a set of factors that contribute to the effectiveness of community coalitions to implement health promotion programs. The study includes implementation as a measure of coalition effectiveness and focuses on the implementation stage of coalition development. Twelve factors in the model include leadership, decision-making, communication, conflict, benefits and costs, organizational climate, staffing, capacity building, member profile, recruitment pattern, organizational structure, and community capacity. Member participation, satisfaction, and quality of action plans were used as measures of coalition effectiveness. The data supported several tenets of the model, including a relationship between action plan quality, resource mobilization, and implementation. Data suggest that members can be satisfied and actively involved but not accomplishing meaningful change.

Coalition Institutionalization
Community members, funding agencies, and broader society have cause for concern when program termination occurs at the point of termination of funding rather than when objectives have been achieved. The social or health problem for which the program was designed may not be solved. Significant start-up costs are incurred and are perceived as a waste of resources when final outcomes are not achieved. Program staff, community coalition members and the community itself will develop diminished trust and support for future program implementation when programs are terminated inappropriately (Shediac-Rizkallah & Bone, 1998).

The institutionalization stage is important for long-term sustainability of programmatic interventions and of the coalition itself. Building community capacity to solve new problems in the future is part of this stage (Butterfoss and Kegler, 2002). While Butterfoss and Kegler have labeled this third stage, institutionalization, other researches prefer a broader view of sustainability and its genesis within coalition building.

Shediac-Rizkallah & Bone (1998) suggest sustainability should be a planned approach rather than a latent goal. They view sustainability as a global, dynamic process that does not imply a static program, in contrast to institutionalization and routinization. Planning for incorporation needs to start early in the project's development (Bracht, Finnegan, Rissel, Weisbrod, Gleason, Corbett, & Veblen-Mortenson, 1994; Freidman & Wicklund, 2006; Pluye, Potvin, & Denis, 2004).

Sustainability encompasses several aspects or strategies including maintaining the benefits of the program over time (Bracht et al, 1994; Shediac-Rizkallah & Bone 1998), resource development and maintaining a funded infrastructure as key to sustaining activities and outcomes (Freidman & Wicklund, 2006; Pluye et al, 2004), and building community capacity (Freidman & Wicklund, 2006; Shediac-Rizkallah & Bone, 1998).

There is a growing recognition that lasting, widespread changes in individual behaviors is best brought about through changes in community norms, systems, and policies (Shediac-Rizkallah & Bone, 1998; Freidman & Wicklund, 2006). Community participation, a key determinant in effective community change, and related constructs of empowerment, ownership, and competence, are increasingly found in the literature as related to a community's capacity to achieve program maintenance and sustain problem solving ability over time (Shediac-Rizkallah & Bone, 1998). Shediac-Rizkallah & Bone (1998) provide a framework for conceptualizing program sustainability and provide a set of guidelines for sustainability planning.

Construct 2: Community Context

CCAT acknowledges the significant impact of contextual factors on coalition effectiveness such as the sociopolitical environment, geography, history of collaboration (contradicted in work done by Mizrahi & Rosenthal, 2001; supported in work done by Roussos & Fawcett, 2000), and norms surrounding collaborative efforts and the issue under scrutiny (Butterfoss & Kegler, 2002). External factors such as the issue, the right timing, and the social target have been found to be critical to success (Mizrahi & Rosenthal, 2001).

Construct 3: Lead Agency/Convener Group

Within this construct, the model proposes that coalitions usually form when a lead entity or convener organization responds to an opportunity, threat, or mandate and provides initial support for the formation stage. The convener organization usually hosts the initial meeting, recruits partners, provides physical space, and provides full or part time staff to manage the initiative (Butterfoss & Kegler, 2002).

The first proposition states that coalition formation is more likely when the convener agency provides technical assistance, financial or material support, credibility, and networks and contacts (Butterfoss & Kegler, 2002). Partnerships are more effective when technical assistance and support are available. This is especially true when coalitions are conducting key processes and activities (Roussos & Fawcett, 2000; Wolff, 2001a).

The second proposition states that formation is more likely to be successful when the convener enlists community gatekeepers to help develop credibility and trust within the community (Butterfoss & Kegler, 2002). Roussos & Fawcett (2000) also found that participation by leaders and gatekeepers increases the number and diversity of those exposed to interventions.

Construct 4: Coalition Membership

The first proposition of membership states that coalitions begin with an initial core group of committed members. The second proposition states that effectiveness is increased when the core group expands to include a broad constituency representative of the diversity of the community. Previous experience with the issue and with coalitions increases member commitment (Butterfoss & Kegler, 2002). Zakocs & Edwards (2006) found that participation, diversity, collaboration, and cohesion enhanced coalition effectiveness.

Broad community engagement is essential to strengthen the capacity of the community to identify, understand, and address complex problems. The problem solving process needs to be structured so that it is feasible for a broad array of people to be involved (Lasker and Weiss, 2003). However, involving the target population, especially minorities and low income, and getting non-health related organizations to participate can be a challenge (Roussos & Fawcett, 2000).

Wells et al. (2004) explored the issue of pluralism, providing support for the hypothesis that coalitions embedded in more pluralistic communities will themselves become more pluralistic. Pluralism in community coalition work is seen as a good thing, using an anthropological definition of pluralism, which refers to the degree to which diverse interests are represented within a community.

Construct 5: Operations and Processes

Five propositions, based on the assumption that effective internal functioning is necessary for progress, fit within this construct: open and frequent communication among staff and members; shared and formalized decision-making (supported by Butterfoss et al, 1996); conflict management; positive relationships among members (supported by Butterfoss et al, 1996); and member perception that benefits outweigh costs of participation (supported by Rogers, et al, 1993) all result in positive outcomes, including member satisfaction, commitment, and empowerment (Butterfoss & Kegler, 2002).

Construct 6: Leadership and Staffing

Without strong leadership and adequate staffing, coalitions cannot move beyond the initial steps of formation. Two propositions state that a strong leadership team and skilled, paid staff both improve coalition functioning, pooling of resources, engagement, and effective assessment and planning. Leader and staff competence are associated with member satisfaction. Adequate staffing with adequate time to dedicate to coalition activities improves intermediate outcomes, as does low staff turnover. Leaders with commitment and a clear and shared vision are associated with success (Butterfoss & Kegler, 2002).

Competent leadership was rated of second highest importance next to commitment in a study by Mizrahi & Rosenthal (2001). Competent leadership is a key determinant of member satisfaction and

participation (Butterfoss, et al, 1996) and can influence the success of collaborative partnerships (Lasker & Weiss, 2003; Wolf, 2001a; Zakocs & Edwards, 2006).

The range of leadership skills necessary to deal with the complexities of coalition building are not likely to be found in a single individual. Successful coalitions often enlist a variety of members and/or outside experts to provide the skills and expertise required during each stage of development (Butterfoss and Kegler, 2002; Roussos & Fawcett, 2000). Effective leaders promote broad and active participation, ensuring that power, control, and influence are broad based and shared through a democratic approach. Strong, facilitative leadership will ensure group dynamics are productive and that all participants are heard (Lasker & Weiss, 2003).

Kumpfer, Turner, Hopkins, & Librett, (1993) developed a theoretical model of coalition team effectiveness hypothesizing that an empowering style of leadership increases member satisfaction and perceptions of team efficacy, ultimately leading to increase in team effectiveness. An empowering style of leadership was defined as leaders who encourage and support team members' ideas and planning efforts, practice democratic decision-making processes, and encourage networking and information sharing. Indicators of perceived empowerment included expectations of members for positive outcomes and commitment to the group. The study supported earlier studies showing that member satisfaction and team efficacy are positively correlated with team effectiveness and that the ability to provide a democratic environment of equality and collaboration enhanced coalition outcomes (Kumpfer et al, 1993).

Alexander, Zakocs, Earp, & French (2006) identified three common characteristics closely associated with coalition project director success: status in the community as an insider; fostering shared leadership; and bridge building between members and the community. Expertise in the subject area and vision were not found to be associated with success.

Coalition members are most satisfied when staff manage a coalition effectively, when there is good communication, and when costs and barriers to participation are low (Rogers et al, 1993). On the other hand, staff were most satisfied when there were formalized rules and procedures, when they had sufficient control over the process and the coalition does not slow things down, and when there was good communication (Rogers, et al, 1993). Community based coalitions with paid coordinators and formal structures are capable of generating significantly higher levels of activity than those without either a paid coordinator or a formal structure (Garland, Crane, Marino, Stone-Wiggins, Ward, & Friedell, 2004).

Construct 7: Structure

This construct's proposition states that having formalized rules, roles, structures, and procedures increases likelihood of several positive coalition outcomes. Routinized operations are more readily sustained (Butterfoss & Kegler, 2002). Zakocs & Edwards (2006) and Wolff (2001a) found that formalization of rules and procedures is associated with coalition effectiveness.

Other organizations are hierarchical while coalitions are flat organizations with shared decision-making ability. Coalitions dominated by government agency staff and power figures from large organizations may, while employing a democratic approach, limit the involvement of marginalized groups by the sheer numbers of those with power (Chavis, 2001).

Construct 8: Pooled Member and External Resources

This construct's proposition recognizes that synergistic pooling of member and external resources results in effective assessment, planning, and implementation strategies. Members are considered one of the greatest resource assets. Members contribute knowledge, skills, expertise, and tangible

items. Outside resources consist of funding, expertise, equipment, and more (Butterfoss & Kegler, 2002).

The flow of resources from members and external funders to the coalition for dispersion where needed is different from other organizations that consolidate resources (Chavis, 2001). Resources have been linked with commitment, longevity, and eventually, power to affect change (Mizrahi & Rosenthal, 2001) and have been shown to enhance partnership effectiveness (Roussos & Fawcett, 2000; Wolff (2001a).

Resources have been identified as a major determinant of synergy, a proximal outcome linking partnership to outcomes. The power of collaboration provides synergy when valuable assets are combined in a collaboration that transcends the limitations and achievements of single entities. Professionals transcend the boundaries of their own organizations to link up with professionals and organizations in other sectors (Lasker, n.d.).

Synergy is the proximal outcome of partnerships that gives collaboration its unique advantage (Lasker, Weiss, & Miller, 2001). Creativity, comprehensive thinking, and a more holistic view of the problem are signposts of synergy (Lasker et al, 2001). A partnership's level of synergy is measured by how well the partnership operationalizes collaborative functions such as goal setting, planning, documenting, communicating, and conducting evaluation (Lasker et al, 2001).

Construct 9: Member engagement

The proposition here states that satisfied and committed members will participate more fully. This results in membership empowerment, a sense of belonging and the achievement of intermediate and long-range outcomes (Butterfoss & Kegler, 2002).

Factors that appear to enhance partnership effectiveness include having a clear vision and mission developed by a full and representative membership (Roussos & Fawcett, 2000). Participants need to have real influence in and control over the process. The collaborative process needs to enable a group of diverse participants to engage with each other over an extended period of time. Group discourse must include listening, empathy, and a common language (Lasker and Weiss, 2003; Wynne, et al, 2006).

Construct 10: Assessment and Planning

Successful implementation is more likely when comprehensive planning and assessment occur. As identified under construct six, quality plans are associated with competent staff and leaders and contribute to successful implementation of coalition activities. Many coalitions fail to produce rigorous plans, possibly due to a lack of expertise in this area (Butterfoss and Kegler, 2002). Developing an action plan for change that identifies what to do, how to do it, and when is a factor in enhancing partnership effectiveness (Roussos & Fawcett, 2000).

Construct 11: Implementation of Strategies

This proposition reiterates evidence that community change is more likely if coalitions' interventions are directed at multiple levels. Successful implementation depends on a number of factors. The use of evidence-based interventions increases likelihood for community change (Butterfoss & Kegler, 2002). Many public health interventions tend to be developed and implemented without explicit reference to any theoretical underpinnings. However, there is evidence that explicit use of theory will significantly improve effectiveness of interventions (Jackson & Waters, 2005). One caveat is the possibility that reliance on evidence-based interventions may decrease coalition engagement (Butterfoss & Kegler, 2002).

Interventions aimed at quick fixes and easy wins may increase coalition solidarity, community trust, and self-efficacy but are less likely to achieve long term capacity building and seldom result in long term, community wide change (Butterfoss and Kegler, 2002).

Wells, Ford, McClure, Holt, & Ward (2007) found that study coalitions were resistant to evidence-based norms, indicating a significant barrier to dissemination of emerging technologies at the local level. The researchers postulate that when coalition members themselves embrace empirical justification of outcomes as part of their professional practice, they may come to be more accepting of regional and national organizations as a means to accomplish their goals than as outsiders seeking to impose norms.

A diverse membership and inclusive information sharing appear to facilitate access to resources for implementing interventions. Resulting interventions tend to have professional legitimacy and grounding in theory. Interventions are more tailored to meet the needs of specific populations. Fewer and less diverse resources and relationships are associated with smaller education initiatives, primarily at the dissemination level, and less people are reached in less varied ways (Wells et al, 2007).

Francisco, Paine, & Fawcett (1993) identified eight key measures of coalition process and outcomes: number of members, planning products, financial resources generated, dollars obtained, volunteers recruited, services provided, community actions, and community changes.

Construct 12: Community Change Outcomes

Emphasis on outcomes by funders has been shown to enhance partnership effectiveness (Roussos & Fawcett, 2000). Implementation strategies that include attention to policies, practices, and environmental factors in addition to individual awareness, education, and behavior change are more likely to achieve long term success as well as increase the community's capacity to address other social and health issues in the future (Butterfoss & Kegler, 2002).

Construct 13: Health and Social Outcomes

CCAT posits that the ultimate indicator of coalition effectiveness is the improvement in social and health outcomes. There is currently little strong evidence to support the effectiveness of coalitions in creating lasting change in social and health outcomes. There is some evidence for creating environmental change. Designs of coalition evaluation strategies do not include measuring long term, more complex constructs (Butterfoss & Kegler, 2002).

Evidence of population level outcomes is lacking in the literature for a number of reasons, the most obvious being that population change may take years or even generations to occur. Studies are not set up to measure outcomes over this length of time (Roussos & Fawcett, 2000).

Construct 14: Community Capacity

The final construct in the CCAT model posits that participation in a successful coalition results in increased community and organizational capacity, builds social capital, and prepares members for dealing with other social and health issues in the future. Capacity refers to dimensions related to leadership, networks, skills and resources, and community solidarity (Butterfoss & Kegler, 2002).

Goodman et al, (1998) describes the dimensions of community capacity identified by participants in a symposium hosted by the CDC to stimulate dialogue on the concept. Identified as central to the construct of community capacity are the dimensions of participation and leadership skills, resources, social and interorganizational networks, sense of community, and understanding of community history, power, values, and critical reflection. Viewed as necessary for the development and

implementation of effective community based health promotion programs, the participants worked towards a common definition and developed a list of dimensions and subdimensions to be used as a point of departure for dialogue.

Zakocs & Guckenburg (2007) define community capacity as features of a community that affect its ability to identify, mobilize, and address public health problems. Organizational capacity was identified as existing local organizations creating new or expanded programs, policies, or services and/or new local organizations being created. Study results found that seven characteristics were shared among coalitions with greatest organizational capacity: more funds were available, creation of a new agency to carry out the work was delayed, organizations housing coalition staff were supportive of the mission, there was stable, participatory decision-making, there was active involvement by government agencies, there was collaborative leadership, and there were effective, long serving project directors.

Community readiness is used in the literature synonymously with capacity among community organizations. Feinberg, Riggs, & Greenberg (2005) looked at the links between community readiness, defined as preexisting community conditions that either promote or undermine initiatives, and the social networks that exist among participants. Authors identified two dimensions of social networks, cohesion/integration and centralization. Cohesion is the extent to which participants are linked to one another. Centralization is the pattern in which one or a few core participants are central, with social ties to many while those on the periphery have social ties to few others. Study findings supported the view that network patterns in which indirect links exist are not conducive to readiness. A positive significant link between key informant reports of readiness and cohesion/integration was found. Authors have concluded that coalitions seem to function better when they are relatively homogenous and non-centralized, where closeness and brokering is not limited to a few core players.

Lasker & Weiss (2003) present a multidisciplinary model called community health governance or CHG that hypothesizes that communities need to achieve three proximal outcomes if they are to strengthen their capacity to solve issues relating to the health and well being of their residents: individual empowerment, bridging social ties, and synergy. The model further hypothesizes that leadership and management facilitate the acquisition of key process characteristics that lead to these proximal outcomes.
The model hypothesizes that communities need collaborative processes that are broad in scope to fully achieve the three proximal outcomes.

Foster-Fishman et al, (2001) conducted a review of the literature and developed an integrated model for building collaborative capacity. The model defines collaborative capacity as the conditions needed for coalitions to promote effective collaboration and build sustainable community change. The model posits that coalitions need collaborative capacity at four critical levels: within members; within their relationships; within their organizational structures; and within the programs they sponsor. The Foster-Fishman model provides an extensive list of core skills and knowledge necessary for building member capacity, relational capacity, organizational capacity, and programmatic capacity.

Conclusion

The CCAT model provides a framework for building and evaluating effective coalitions. While the model was developed from published studies of community coalition work, it is reasonable to test the model's application to the development of a statewide coalition. The model could be used as a framework for building a coalition from the ground up: for guiding coalition structure and process formation, guiding coalition maintenance, and as a standard for identifying coalition effectiveness indicators.

References

Alexander, M., Zakocs, R., Earp, J., & French, E. (2006). Community coalition project directors: What makes them effective leaders? *Journal of Public Health Management Practice*, *12(*2), 201-209.

Bracht, N., Finnegan, J., Rissel, C., Weisbrod, R., Gleason, J., Corbett, J., & Veblen-Mortenson, S. (1994). Community ownership and program continuation following a health demonstration project. *Health Education Research, 9(*2), 243-255.

Butterfoss, F., Goodman, R., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research, 8(*3), 315-330.

Butterfoss, F., Goodman, R., & Wandersman, A. (1996). Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation, and planning. *Health Education Quarterly, 23(*1), 65-79.

Butterfoss, F. & Kegler, M. (2002). Toward a comprehensive understanding of community coalitions: Moving from practice to theory. In *Emerging theories in health promotion practice and research*. R. DiClemente, R. Crosby, & M. Kegler (Eds.) (pp. 157-193). San Francisco: Jossey-Bass.

Butterfoss, F., Lachance, L., & Orians, C. (2006). Building allies coalitions: Why formation matters. *Health Promotion Practice*, *7(*2) 23s-33s.

Butterfoss, F (2008). Personal conversation, Heart Disease and Stroke Institute, Atlanta, GA.

Chavis, D. (2001). The paradoxes and promise of community coalitions. *American Journal of Community Psychology, 29(*2), 309-320.

Feinburg, M., Riggs, N., & Greenberg, M. (2005). Social networks and community prevention coalitions. *The Journal of Primary Prevention*, *26(*4), 279-298.

Foster-Fishman, P., Berkowitz, S., Lounsbury, D., Jacobson, S., & Allen, N., (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, *29(*2), 241-261.

Francisco, V., Paine, A., & Fawcett, S. (1993). A method for monitoring and evaluating community health coalitions. *Health Education Research, 8(*3), 403-416.

Friedman, A. & Wicklund, K. (2006). Allies Against Asthma: A midstream comment on sustainability. *Health Promotion Practice, 7(*2), 140s-148s.

Garland, B., Crane, M., Marino, C., Stone-Wiggins, B., Ward, A., & Friedell, G. (2004). Effect of community coalition structure and preparation on the subsequent implementation of cancer control activities. *American Journal of Health Promotion, 18(*6), 424-434.

Goodman, R., Speer, M., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., Smith, S., Sterling, T. & Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior, 25(*3) 258-278.

Jackson, N. & Waters, E. (2005). Criteria for the systematic review of health promotion and public health interventions. *Health Promotion International Advance Access*. Retrieved on July 10, 2007 from http://heapro.oxfordjournals.org.

Kegler, M., Steckler, A., Malek, S., & McLeroy, K. (1998). A multiple case study of implementation in ten local Project ASSIST coalitions in North Carolina. *Health Education Research*, *13(*2), 225-238.

Kegler, M., Steckler, A., McLeroy, K., & Malek, S. (1998). Factors that contribute to effective community health promotion coalitions: A study of ten project ASSIST coalitions in North Carolina. *Health Education and Behavior, 25(*3), 338-353.

Kumpfer, K., Turner, C., Hopkins, R., & Librett, J. (1993). Leadership and team effectiveness in community coalitions for the prevention of alcohol and other drug abuse. *Health Education Research, 8(*3), 359-374.

Lasker, R. (n.d.). *Medicine and public health: The power of collaboration* [Monograph]. Retrieved on July 10, 2007 from http://www.cacsh.org/mph.html.

Lasker, R. & Weiss, E. (2003). Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *80(*1), 14-49.

Lasker, R., Weiss, E., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Millbank Quarterly*, *79(*2), 179-205.
Mizrahi, T. & Rosenthal, B. (2001). Complexities of coalition building: Leaders' successes, strategies, struggles, and solutions. *Social Work, 46(*1), 63-78.
Pluye, P., Potvin, L., & Denis, J. (2004). Making public health programs last: conceptualizing sustainability. *Evaluation and Program Planning*, *27,* 121-133.
Rogers, T., Howard-Pitney, B., Feighery, E., Altman, D., Endres, J., & Roeseler, A. (1993). Characteristics and participant perceptions of tobacco control coalitions in California. *Health Education Research, 8(*3), 345-357.
Roussos, S. & Fawcett, S. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*, *21,* 369-402.
Shediac-Rizkallah, M. & Bone, L. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research, practice, and policy. *Health Education Research, 13(*1), 87-108.
Wells, R., Ford, E., Holt, M., McClure, J., & Ward, A. (2004). Tracing the evolution of pluralism in community-based coalitions. *Health Care Management Review, 29(*4), 329-343.
Wells, R., Ford, E., McClure, J., Holt, M., & Ward, A. (2007). Community-based coalitions' capacity for sustainable action: The role of relationships. *Health Education and Behavior, 34(*1), 124-139.
Wolff, T. (2001a). A practitioner's guide to successful coalitions. *American Journal of Community Psychology, 29(*2), 173-191.
Wynn, T., Johnson, R., Fouad, M., Holt, C., Scarinci, I., Nagy, C. Partridge, E., Dignan, M., Person, S. & Parham, G. (2006). Addressing disparities through coalition building: Alabama REACH 2010 lessons learned. *Journal of Health Care for the Poor and Underserved, 17,* 55-77.
Zakocs, R. & Edwards, E. (2006). What explains community coalition effectiveness? A review of the literature. *American Journal of Preventive Medicine, 30(*4), 351-361.
Zakocs, R. & Guckenburg, S. (2007). What coalition factors foster community capacity? Lessons learned from the Fighting Back Initiative. *Health Education and Behavior, 34(*2), 354-375.

Figure 1. Community Coalition Action Theory (CCAT)