

Contributions of Community Involvement to Organizational-Level Empowerment: The Federal Healthy Start Experience

Meredith Minkler, DrPH
Mildred Thompson, MSW
Judith Bell, MPA
Kalima Rose, PhD

This article presents findings of a multisite case study of the experience of nine federal Healthy Start Program sites in using consortia and other community involvement strategies in the fight against infant mortality. Using empowerment theory as a conceptual framework, qualitative data are employed to examine how community involvement in the program through community-based consortia and other means contributed to empowerment at the organizational level. The article concludes with implications of the study findings for practice both within Healthy Start and in the context of other community-based health initiatives.

Community initiatives frequently operate within a “catalyst for change” model,¹ attempting to “transform relevant sectors of the community, changing programs, policies and practices to make healthy behaviors more likely for large numbers of people” (p. 7). Often, such models are based on theories of empowerment and stress multiple interrelated activities, including collaborative planning, community action, and institutionalization of change processes and outcomes.¹

A critical intermediate variable between community health intervention programs and the achievement of health outcomes is believed to lie in the ability of these programs to enhance community capacity and create conditions that facilitate empowerment.¹⁻⁶

As Kreuter et al.⁷ have pointed out, however, “health systems and health status change are not only difficult to achieve, but also difficult to *detect*—at least in a form that is attributable to any particular intervention” (p. ii). Yet, as they go on to note, collaborative work,

Meredith Minkler is a professor in the School of Public Health at the University of California, Berkeley. Mildred Thompson is a senior policy fellow, Judith Bell is vice president, and Kalima Rose is a senior associate at PolicyLink, Oakland, California.

Address reprint requests to Meredith Minkler, School of Public Health, University of California, Berkeley, Berkeley, CA 94720-7360; phone: (510) 642-4397; fax: (510) 643-8236; e-mail: mink@uclink4.berkeley.edu.

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including community involvement through consortia and coalitions, may have important by-products, including “individual and community capacity, increased levels of trust [and] responsiveness to community needs.” These by-products, which often reflect increased individual, organizational, and community empowerment, are increasingly viewed as “worthwhile intermediate payoffs” in and of themselves (p. iii).

This article will present the National Healthy Start Program (NHSP) as an example of a program with a mandate that explicitly promotes empowerment at multiple levels. To achieve its goal of dramatically reducing infant mortality in high-risk communities, the NHSP encourages individual, community, and organizational empowerment through community involvement.⁸

Using qualitative data from a study of nine Healthy Start sites across the country, this article will illustrate how community involvement in the NHSP contributed to empowerment at the organizational level, principally through the development and nurturing of community-based consortia. Although the various levels of empowerment are closely interrelated, we have chosen to focus on empowerment at the intermediate or organizational level, since the heavy accent placed by Healthy Start on community-based consortia represents perhaps the most unique aspect of the program.

The study on which this article is based⁹ was conducted by staff and associates of PolicyLink, a national policy, research, communications, and capacity-building organization founded in 1999. PolicyLink’s stated goal is to advance a new generation of policies, guided by the wisdom and experience of local constituencies, to achieve social and economic equity and build strong organized communities. This goal made community involvement in Healthy Start a logical topic for study. Following a brief review of the NHSP and its emphasis on community involvement, empowerment theory will be presented as a broad conceptual framework for the study. Our research questions and methods then will be described, followed by findings concerning organizational-level empowerment at the nine Healthy Start sites examined and implications for policy, practice, and further research.

THE NATIONAL HEALTHY START PROGRAM

The United States ranked 22nd in the world in infant mortality when the Healthy Start Program was launched in 1991, and Black babies were dying at more than twice the rate of White babies.^{10,11} Established with the goal of reducing infant mortality by 50% in 5 years within 15 demonstration sites where infant death rates were at least 15.7 per 1,000 live births, the program is administered by the Health Resources and Services Administration’s (HRSA) Maternal Child Health Bureau.⁸ The NHSP was backed by substantial funding (the allocation for 2001 is \$90 million)¹² and committed to an approach that included a heavy emphasis on community involvement. Indeed, as Badura⁸ has noted, the program was “founded on the premise that the communities themselves could best develop the strategies necessary to attack the causes of infant mortality and low birth weight, especially among high risk populations” (p. 263).

One criterion by which sites were selected by HRSA for participation in the program was the degree of consumer and community involvement demonstrated in their application process. HRSA’s initial *Guidance for the Healthy Start Program*¹³ emphasized this approach, stating,

Consumer participation must be a central consideration in organizing a Healthy Start project. The participation is expected to be substantive and informed. It should begin with the initial conceptualization of the project and continue through all stages including original organization, planning and development, implementation and evaluation. (p. 4)

The grantee agency for each Healthy Start award (e.g., a health department, nonprofit organization, or other entity) was required to organize a consortium whose composition reflected a partnership of consumers, service providers, both public and private community groups, and other stakeholders. In recognition of the role that community capacity building may play in helping to address major health and social problems, the *Guidance for the Healthy Start Program*¹³ further stated that “in addition to system change and service integration for women and infants,” each Healthy Start program must be able to “explain the impact the project has had on developing and empowering the community” (p. 10). The areas in which such empowerment was to be demonstrated included establishing a mechanism for community participation, enhancing community problem-solving skills, providing leadership training, and creating jobs in the community.

While allowing for considerable flexibility in how these goals were to be met, the very requirement that Healthy Start projects address empowerment as a central part of their modus operandi yielded considerable attention to this intermediate variable within project planning and evolution. Healthy Start sites, which had grown in number to 94 by the late 1990s, were instructed by HRSA not to supplant existing funding streams but to be creative in their use of resources. The program’s broad vision of empowerment was further reinforced in the program *Guidance for the Healthy Start Program* issued in 1996¹⁴ with respect to the evaluation of Healthy Start programs. Evaluators were instructed to include in their analyses “empowerment training of community leaders, creation of jobs within the community and leadership training of front-line workers and consumers” (p. 10).

Healthy Start’s program offerings included flexible dollars and program design, a 9-month planning process, the freedom to address community-identified needs, and mandated community involvement. All of these features signaled a new era in comprehensive, client-based service delivery. As Howell et al.¹⁵ have suggested, however, it was the emphasis of Healthy Start on community involvement that was probably its “defining feature,” setting it apart from other maternal child health programs.

In October 2000, after 9 years in the demonstration phase, Healthy Start was authorized as a permanent program when President Clinton signed into law the Children’s Health Act of 2000.¹⁶ Because the act specifically mandated community involvement as a central program feature, new research focused on Healthy Start’s experience with community involvement is particularly timely for this program and other community health initiatives.

The present study builds in part on earlier research on the Healthy Start experience by Plough and Olafson¹⁷ as well as Howell and her associates.¹⁵ The former study provided a detailed case study of the first 2 years of one of the original Healthy Start sites (Boston) from a community empowerment perspective. The authors explored the difficulties and successes experienced, as well as the power dynamics and conflicts they found to be “inherent in a model that is defined and controlled by the federal government and that simultaneously calls for substantial community participation and control” (p. 232).

In their more recent analysis of community involvement in the 15 original Healthy Start sites, Howell et al.¹⁵ identified and contrasted a *service consortium model* (e.g.,

where the community was involved primarily through a consortium of local providers) and a *community empowerment model* (e.g., involving a broad range of community stakeholders and strategies, including contracting with local community-based organizations, hiring and training lay health workers, and fostering community economic development). Although each Healthy Start site was seen as having borrowed from aspects of each model, the different sites also each appeared to reflect primarily one or the other of these models. Howell et al. suggested that despite the many difficulties confronted by the various projects in attempting to involve community, “most have shown a true commitment to the process and feel that any improvement in prenatal care and birth outcomes will be due, in part, to the degree to which the community involvement strategies succeed” (p. 312).

The present article complements this earlier work by examining the ways in which Healthy Start consortia and other community involvement strategies were employed to enhance organizational empowerment and capacity building at eight of the original Healthy Start sites, as well as one of the newer program sites.

CONCEPTUAL FRAMEWORK

Empowerment theory constituted a broad theoretical framework for this study. A multilevel construct, empowerment is defined by Rappaport¹⁸ as an enabling process through which individuals and communities take control over their lives and their environment. As Wallerstein¹⁹ has noted, it is “a social action process by which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life” (p. 198).

Regardless of the level of empowerment being considered, Zimmerman²⁰ suggests that three key factors—participation, control, and critical awareness—are involved. At the individual level of analysis, these factors include a person’s belief in his or her ability to exert control, involvement in decision making, and an understanding of causal agents. Similarly,

Applying this general framework to an organizational level of analysis suggests that empowerment may include organizational processes and structures that enhance member participation and improve organizational effectiveness for goal achievement. At the community level of analysis, empowerment may refer to collective action to improve the quality of life in a community and to the connections among community organizations and agencies. (p. 44)

From the perspective of community-based interventions like Healthy Start, these diverse levels of empowerment are unified by the belief that “the primary goal of community practice is not to help individuals or communities to accept or adjust to problems but to help them develop the ability to change negative situations and prevent the recurrence of problems” (p. 63).²¹ However, and while acknowledging their interrelated nature, exploring each level of empowerment independently can help us understand its characteristics and processes within these different domains. As noted above, this article focuses chiefly on the organizational level of empowerment, with community involvement through consortia as the primary focus of analysis.

For the purposes of this study, a community-based consortium²² is defined as

a partnership of organizations and individuals representing consumers, service providers, and local agencies or groups who identify themselves with a particular community, neigh-

borhood, or locale and unite in an effort to collectively apply their resources to the implementation of a common strategy for the achievement of a common goal within the community. (p. 72)

Although having much in common with coalitions, consortia include individuals as members, while coalitions typically are defined as having only organizations as members.²³ The original *Guidance for the Healthy Start Program*,¹³ for example, included the stipulation that “the consortium must include representation that reflects a partnership of consumers, providers of services and community organizations and groups, both public and private” (p. 10).

Earlier research has helped illuminate the linkage between participation in voluntary organizational entities and empowerment.²⁴⁻²⁷ A popular definition of citizen participation as “a process in which individuals take part in decision making in institutions, programs and environments that affect them” (p. 339)²⁷ thus has much in common with the definitions of empowerment cited above. As Wandersman and Florin²⁵ have noted, participation in voluntary community organizations can be empowering because of its relationship to “higher competencies, confidence, sense of citizen duty and lower feelings of helplessness” (p. 45). Although consortia are not single organizations, participation in such entities similarly can be empowering for both individual and organizational members.²² Participation thus is critical in designing programs, plans, or environments that reflect local values and concerns while increasing participants’ sense of control over the environment and their “feelings of helpfulness and responsibility” (p. 265).²⁴

In examining the extent to which Healthy Start sites and their consortia contributed to empowerment at the organizational level, we use Zimmerman’s²⁰ conceptualization of empowering and empowered organizations. As he has noted,

A distinction must be made between what the organization provides to members and what the organization achieves in the community. Organizations that provide opportunities for people to gain control over their lives are *empowering* organizations. Organizations that successfully develop, influence policy decisions, or offer effective alternatives for service provision are *empowered* organizations. (p. 51, emphasis added)

While the notion of an empowering organization refers to a *process*, the empowered organization may be seen as an *outcome*.²⁰ We use Zimmerman’s²⁰ characteristics of potentially empowered organizations as including the following (see Table 1):

- Successful growth and development
- Effective competition for resources
- Partnering or “networking with other organizations”
- Influencing policy decisions

In our analyses of organizational empowerment as *process*, we also draw from the work of Maton and Salem,²⁸ who have elucidated four organizational characteristics of empowering community settings:

- A culture of growth or belief system that “inspires growth, is strengths-based, and is focused beyond the self”
- The provision of opportunities for participants to occupy diverse and meaningful roles

Table 1. Empowering Strategies, Processes, and Outcomes at the Organizational Level

| Strategies for Facilitating Empowerment ^a | |
|--|---|
| Enhance experience and competence | Remove social and environmental barriers |
| Enhance group structure and capacity | Enhance environmental support and resources |
| Process: Empowering Organizations ^b | Outcome: Empowered Organizations ^c |
| Culture of growth and community building | Successful growth and development |
| Opportunities for members to take on meaningful and multiple roles | Effectively competing for resources |
| Peer-based support system that helps members develop a social identity | Networking with other organizations |
| Shared leadership with a commitment to both members and the organization | Influencing policy |

a. Adapted from Fawcett et al. (1995).⁶

b. Adapted from Maton and Salem (1995).²⁸

c. Adapted from Zimmerman (2000).²⁰

- A support system that is “encompassing, peer-based, and provides a sense of community”
- Collaborative leadership “committed to both setting and members” (p. 631)

Finally, we draw from the work of Fawcett et al.⁶ who elucidated four important strategies for facilitating the empowerment process and related outcomes: “(a) enhancing experience and competence, (b) enhancing group structure and capacity, (c) removing social and environmental barriers, and (d) enhancing environmental support and resources” (p. 679). In this article, we draw on study themes (see Table 2) and other findings to demonstrate how various combinations of these strategies could be observed at many of the Healthy Start sites and consortia examined in relation to empowerment processes and outcomes at the organizational level.

RESEARCH QUESTIONS

Central to our study were four questions:

1. What is the nature and functioning of the community involvement component at each Healthy Start site examined?
2. What conditions and processes contribute to well-functioning consortia and other community involvement efforts? What barriers and obstacles impede such functioning?
3. How do Healthy Start directors, consortia chairs, and other key informants at each site view the community involvement component of the program and judge its quality and relationship to outcomes?
4. Did the community involvement component of Healthy Start result in, or contribute to, systems or community changes such as new or modified programs, policies,

Table 2. Cross-Cutting Themes^a

 Themes Identified by All Three Reviewers

The diversity of consortia structures and community involvement strategies
 Emphasis on community empowerment and capacity building
 Attention to the community's felt needs and concerns
 Race- and class-based tensions and efforts to address them
 Provider-consumer tensions and their playing out in the consortia
 The prominent role of training and health education
 The impact of contextual factors such as environmental and demographic changes
 The role of community involvement in new program development
 Barriers and challenges to community involvement
 Institutionalization of new or modified programs or practices

 Themes Identified by Two Reviewers

Formation of alliances and partnerships
 Stories of success from the individual to the community level
 Limited articulation of the role of community involvement in influencing policy

a. Adapted from Thompson et al. (2000).⁹

or practices? If so, what were the changes or modifications, and in what specific ways were the consortia or other community involvement approaches involved?

Although it is beyond the scope of this article to address each of these research questions (see Thompson et al. 2000),⁹ we draw on findings related to aspects of each question as they inform our understanding of the contribution of community involvement to organizational-level empowerment through Healthy Start.

METHOD

A multisite case study design²⁹ was identified as the best method for addressing the project's research questions. This approach also was selected because although we anticipated finding some important commonalities across sites, each Healthy Start program examined would have contexts, conditions, and processes of change⁶ that would require in-depth exploration as we focused on the area of community involvement.

Role of the Advisory Committee

To create a working partnership that would foster critical discussion, planning, review, and implementation of the project's goals, a 15-member advisory committee was constituted and actively involved in study design, questionnaire construction, and other aspects of the project. The advisory group included individuals knowledgeable about Healthy Start and community involvement, researchers, policy advocates, physicians, and Healthy Start program participants and consortia members from several of the study sites. Although the full advisory board met with the project team only twice, individual members and subgroups were consulted as needed throughout the project period and provided

crucial feedback on site selection and study design, interpretation of findings, and development of recommendations and study products.

Site Selection

Site selection was undertaken with the goal of achieving a sample that was diverse along multiple dimensions and that was suitable for addressing our research questions as outlined above. We wished to include, for example, both urban and rural sites; sites with different levels of achievement of health outcome objectives; and sites that were sources of both positive lessons and lessons concerning barriers, tensions, and areas for improvement. Nine sites were selected in consultation with staff at the National Healthy Start Office and our advisory committee: Boston, Chicago, Cleveland, Kansas City, Philadelphia, Pittsburgh, New Orleans, New York City, and Pee Dee (South Carolina). With the exception of Kansas City, each site was among the original 15 selected for participation in the NHSP.

Development of Data-Gathering Instruments

A standardized semistructured questionnaire for key informant interviews was developed by the project director and research consultant and extensively modified based on pretesting in a nonparticipating Healthy Start site (Oakland, CA) and input from the advisory committee and consultants at the NHSP Office. The final instrument included 29 questions, several with a number of subparts, under the subheadings Consortium, Processes of Community Involvement Beyond the Consortium, and Outcomes and Side Effects of Community Involvement. The schedule included questions concerning how *community* and *community involvement* were defined at each site; consortia history, membership, and nature and levels of participation; selection criteria; and factors contributing to, and impeding, consortia functioning. Questions concerning community involvement beyond the consortia, opportunities for training and upward mobility, and both positive and negative outcomes and side effects of community involvement in Healthy Start also were included.

A seven-item focus group guide also was developed by the project director and research consultant, with considerable input from the advisory committee. Questions concerned general background and personal history of involvement with the program, nature and scope of any training received, perceptions of consortia functioning and responsiveness to the participants' concerns, and suggestions for improvement. Respondents further were asked to describe whether there had been changes in themselves, their families, or their community as a result of their being Healthy Start participants and/or consortium members, and if so, to describe these changes.

Site Visits

Each site was visited during a 2-day period by the PolicyLink Project, Director Mildred Thompson, and one to three other members of the PolicyLink team, with a follow-up visit conducted for additional data collection. In addition to key informant interviews and focus groups, the site visits typically included informal meetings with additional staff, observations of consortia meetings and/or other relevant activities, and collection of project reports or other pertinent written materials.

Key Informant Interviews and Informal Meetings

At the heart of our data collection were key informant interviews, using the interview schedule described above, with between two (Cleveland) and five (Philadelphia) individuals. Interviews typically were conducted in the respondents' offices and took 60 to 90 minutes to administer. The two key respondents at each site (project director and consortium chair) were always interviewed independently of one another to facilitate openness and an ability to compare responses. Individual or joint interviews were conducted with other staff members at most sites who were chosen to participate based on their history of involvement with the program. All subjects were informed of the voluntary nature of their participation, and interviews were recorded with their permission.

At several sites, research team members met informally with outreach workers and/or other staff members. These sessions frequently included several individuals and used questions from the formal interview schedule only to the extent appropriate for the parties concerned. They also were tape-recorded and transcribed with permission of the participants.

Focus Groups

To enable us to hear the voices of program participants and consortia members more directly, a focus group was conducted with four to nine individuals at each site. Group participants were volunteers identified by the consortium chair or a Healthy Start staff member and typically had been involved with the consortium at their site. Participants each signed a consent form and received a \$50 honorarium for their participation in the 45- to 90-minute group.

Observations

Site visits typically were scheduled to coincide with consortium meetings or subcommittee meetings and/or other relevant events that the research team could observe. Efforts also were made to visit family resource centers and other key program components as part of the data collection.

Collection of Documents and Background Data Review

An attempt was made to collect from each site written data in the form of newsletters, consortia bylaws, recent reports, newspaper articles, or other documents that might capture additional insights about the community involvement component of the project. Because of considerable variability between sites, comparable materials often were not available from each program.

Data Management and Analysis

Following each site visit, the project director developed a one-page overview, summarizing information for each site under headings including Fiscal Agent, Consortia, Committees, Structure, Governance, Program, and Unique Features and Outcomes (see first four columns of Table 3). To ensure accuracy and begin the process of giving data back to the community in accordance with the study's commitment to empowerment, each of

(text continued on pg. 796)

Table 3. Healthy Start Site Profiles^a

| Site | Fiscal Agent | Consortia | Consortia's Role in Governance | Program Features | Sample Features | |
|--------------|---|--|---|--|--|---|
| | | | | | Empowering Organizations | Empowered Organizations |
| Pittsburgh | Allegheny County Health Department; passes funds through to Healthy Start nonprofit | Regional model with one consortium in each of six target areas | Policy decisions on type and level of services Input on budget and personnel decisions | Case management model in six service areas Drug and alcohol prevention Male initiative program | New member orientations and formal written evaluations of each consortium meeting | Codeveloped two new residential treatment programs Formed 501c3 |
| Philadelphia | Philadelphia Department of Public Health, Maternal Child Health | Very strong consumer participation model with six committees | Policy decisions on type and level of services | Outreach model with risk reduction and adolescent focus | Daylong event to build trust between providers and community members of consortium | Activist community organization now runs consortium with little involvement of Healthy Start staff |
| Boston | Boston Public Health Commission | Very strong consumer participation model with seven committees | Policy decision on type and level of services Influence on outreach strategies and marketing tools | Case management with strong home visitation component | Strong leadership training with requirement of participation in another community initiative | Developed health centers in public housing facilities |
| Chicago | State of Illinois, Department of Human Services | Very strong consumer participation model with three committees | Policy decisions on type and level of services | Five family resource centers and subcontractors Prison-based program for pregnant and parenting women | Consumer conference on issues identified by participants | Community Mobilization Committee catalyzed successful fight for exemptions from welfare reform's work |

| | | | | | | |
|-------------|---------------------------------------|--|--|--|--|---|
| | | | | | | requirements for mothers of special-needs children |
| Kansas City | Heart of America United Way | Strong provider representation with three committees | No involvement in governance | Case management Enhanced clinical services, outreach, training, and education | Accent on cultural sensitivity (e.g., consortium-sponsored conference on working with growing Hispanic population) | Consortium helped expand teen pregnancy prevention program in local schools |
| Cleveland | Cleveland Department of Public Health | Eight sites serving 15 neighborhoods | Executive Council and Administrative Management Group makes policy decisions | Case management Case management and health education in correctional facilities Mobile health clinic | Participants work with business representatives and other stakeholders on Consortium Leadership Committee | Outreach workers came to consortium to devise new housing partnerships Consortium graduates began Neighborhood Forum; meets bi-monthly and works with other groups |
| Pee Dee | Private, nonprofit | Separate consortia for providers and consumers, now working more closely together Additional consortia focused on men | Agency's board of directors makes governance decisions | Rural program that serves six counties Primarily an outreach model Male component educates fathers and potential fathers | Creation of bus system to enable resident attendance at consortium meetings and other activities Beginning forma- | Formed 501c3 Played leadership role in advocacy for health insurance for region's part-time workers Facilitated transfer |

Table 3. Continued

| Site | Fiscal Agent | Consortia | Consortia's Role in Governance | Program Features | Sample Features | |
|-------------|--|---|--|--|---|---|
| | | | | | Empowering Organizations | Empowered Organizations |
| | | | | | tion of regional consortium to bring consumer and provider groups together | and institution- alization of ROADS program after funding cuts |
| New Orleans | City of New Orleans, mayor's office receives funds; passes through to Great Expectations Foundation, a 501c3 | 10 Service Area Advisory Councils represented on Consortia Steering Committee 4 leadership council members and 3 consumer representatives make policy decisions on Great Expectations Board of Directors | Consortia Steering Committee makes recommendations on service delivery models, identifies community needs and partnerships Some input on budget and personnel decisions | 10 target areas served at three multi-service centers Abstinence and teen pregnancy programs Case management model HIV/AIDS case management | Inclusive strategic planning process and follow-up allocation of minigrants by consortium Two consortium members added to board of new nonprofit Data sharing and education of consumers to create critical awareness about links between IM and other problems | Created 501c3 Located and managed alternative funding streams Community activists on steering committee brought stronger resources |
| New York | Medical and Health Research Associ- | Regional model with five citywide com- | Local consortia representatives are | Case management male involvement | Increased critical awareness about | Formed coalition of 20+ male involve- |

| | | | | | |
|---|--|--|---------|---|---|
| ation of New York City, Inc. (grantee) | mittees and three Harlem Local Area committees | members of city- wide consortium that makes governance- level decisions | program | domestic violence led to training of 19 peer educators Leadership training expanded after budget cuts to include sessions on grant writing | ment programs Created job training center Partnered with Health Department and Children's Defense Fund on immunization campaign |
|---|--|--|---------|---|---|

a. Adapted from Thompson et al. (2000).⁹

these summary pages was returned to the site's project director and consortium chair for review and feedback. Their corrections and validation are reflected in the data that appear in Table 3 and in the Findings section.

To prevent the loss of valuable first-impressions data, site visitors also provided the rest of the research team with both a verbal and a written self-debriefing, typically within 1 week of the visit. Audiotapes from each interview and focus group were transcribed verbatim by a professional transcriber.

The primary research team members involved in data analysis were the project director, who formerly directed a nonparticipating Healthy Start site and had extensive experience with the program both locally and nationally; a consultant with expertise in community involvement and in community-based public health research; and a health education/social work doctoral student working with the consultant. Each of these individuals reviewed the transcripts independently by site to identify (1) patterns related to the project's research questions and (2) emerging themes within each site, whether or not these were directly related to the research questions. The latter process enabled us to take full advantage of the qualitative nature of the data by remaining open to new insights and findings that, although not tapped through the research questions, might provide additional avenues for understanding the program's community involvement component.

Considerable variability was found between sites in terms of both the nature and extent of data gathering that were possible and the applicability of portions of the main data-gathering instrument. Therefore, in lieu of a more formalized coding template, the three researchers each read the transcripts several times, using open coding to identify possible patterns and themes that were then listed as informal codes in marginal notes. Codes that emerged in this process included, for example, broad view of community, attention to community needs and concerns, racial/ethnic tensions, creative partnerships, and limited role in governance. Each reviewer then examined the codes she had identified by site to reveal those that had emerged in relation to most or all of the sites examined. She then developed her own list of 10 to 15 key cross-site codes or themes. The three sets of cross-site themes then were compared. As shown in Table 2, 10 themes were identified by all three reviewers, with an additional three themes identified by two. This high degree of interrater correspondence gave us confidence that the 13 themes identified through the open coding process represented more than a single individual's perception of the major issues that emerged from the data at the different sites. This was particularly important since only one of the research team members (the project director) was directly involved in data collection at every site. The 13 themes identified, plus additional data from review of documents and the site visitors' observational notes and subsequent debriefings, were then used to help address the study's research questions. (See Thompson et al.⁹ for a fuller discussion of study methods and findings relevant to aspects of the research questions not addressed in this article.)

Study Limitations

This study had a number of limitations including the small number of participating sites (9 out of a total of 94 Healthy Start programs), the relatively brief time available for site visits, and the cross-sectional nature of data collection. The latter factor prevented us from examining consortia growth and development over time using models that have demonstrated utility in such analyses.^{6,7,30-32}

As noted above, while the diversity of the selected sites was advantageous in helping us to examine a broad range of consortia and their programmatic and community settings,

it was difficult to design a main data collection instrument that was of comparable relevance to each site. The lack of comparable written materials for the different sites also made this aspect of data collection and analysis less helpful than the interviews, focus groups, and observational components of the study. Finally, as noted earlier, although empowerment ideally should be examined at multiple levels simultaneously, space limitations in the present article necessitated our focusing on a single level. Bearing in mind these limitations, however, this article attempts to illuminate our understanding of the contributions of community involvement in comprehensive health initiatives like Healthy Start to organizational-level empowerment.

FINDINGS

The major means through which Healthy Start contributed to organizational empowerment, and a key focus of this study, involved the creation, implementation, and sustaining of community-based consortia. Although each Healthy Start program was required by legislative mandate to create a consortium, there was considerable flexibility in what such consortia should look like and how they should operate.^{8,17} The resulting diversity of consortia structures and community involvement strategies was a primary theme identified in our study (see Table 2).

The high degree of autonomy granted to the sites by HRSA enabled several Healthy Start programs to build on preexisting organizations or networks, resulting in overall enhanced capacity or problem-solving ability. As suggested in Table 3, for example, both New Orleans and Cleveland developed a network consortia structure, bringing together in the process a number of preexisting neighborhood organizations. More often, however, the consortium was a more unitary structure with several subcommittees that engaged in varying levels of information sharing and governance. In the next section, we examine some of the ways in which these diverse consortia fit the criteria of empowering and empowered organizations.

Healthy Start Consortia as Empowering Organizations

At many sites, Healthy Start's community-based consortia played the role of empowering organizations by creating settings in which people could participate, develop critical awareness, and act together to gain increased control over their lives.²⁰ The consortia further illustrated, to differing degrees, Maton and Salem's²⁸ four characteristics of an empowering organization by (1) creating a culture of community and growth, (2) providing opportunities to occupy diverse and meaningful roles, (3) offering a support system fostering peer support and social identity and, (4) facilitating collaborative leadership.

Culture of community and growth. Many of the themes that surfaced in this study (e.g., the emphasis on community capacity building, attention to community-identified needs and concerns, the prominent role of training and health education, and efforts to address tensions based on race and class) were integrally related to the creation of a culture of community and growth. In Chicago, an annual 2-day Consumer Conference, which provided health education, leadership training, and opportunities for networking and celebration, was planned by the consortium's Community Mobilization Committee and attended by 250 to 300 people. Both "enhancing experience and competence" at the

individual and group levels and “enhancing group capacity”⁶ were among the empowering strategies employed in the planning and conducting of this event.

Kansas City fostered a culture of community and growth by emphasizing cultural sensitivity, including the consortium’s hosting of a conference to address the need for increased cultural awareness and competency related to a growing Hispanic population. Both special events like these and the day-to-day emphasis on creating a sense of community among consortia members, providers, and program participants demonstrated the various site consortia’s commitment to this aspect of becoming empowering organizations.

As suggested above, an important feature of the culture of growth described by Maton and Salem²⁸ involves its focus on helping members “look beyond themselves” to view themselves as part of a larger whole or mission. This reflective feature of empowering organizations complements Zimmerman’s²⁰ notion of critical awareness as a vital part of the empowerment process. Many of the Healthy Start consortia fostered critical awareness or “the capacity to analyze and understand one’s social and political environment”²⁰ and with it the ability to look beyond the self (pp. 46-47). Through town hall meetings, subcommittees, and other activities, the consortia provided settings where residents were encouraged to identify and discuss the interconnections between infant mortality and other problems affecting their daily lives and the life of their community. In New Orleans, bar graphs and other visual displays of data on HIV/AIDS, high school drop-out rates, and other community problems were used to educate members about the interrelationships between these and other issues of importance in their own lives. At other sites, dialogue alone was a powerful means of helping consortium members and others understand the intersections between, and root causes of, many of the problems they had identified. Arguing the need for Healthy Start to do more in the area of mental health, for example, one consumer member of the consortium reflected, “If you want healthy babies and a healthy start, you gotta have a healthy mama and a healthy environment.”

In Pee Dee, New York City, and New Orleans, critical awareness of the connection between women’s personal experience with domestic violence and the problem of infant mortality was fostered through the consortia. Follow-up actions included the training of 19 violence prevention peer educators in Central Harlem who also helped make a videotape on this topic, enhancing their experience and competence while increasing environmental support and resources. Finally, growing critical awareness was witnessed with respect to the need for greater inclusiveness, with Boston members, for example, stressing the need to include Chinatown in their Healthy Start’s target area. As will be illustrated below, such critical awareness sometimes led to collective action for change that further contributed to the perception and the reality of Healthy Start consortia as empowered, as well as empowering, organizations.

Opportunities for occupying diverse and meaningful roles. Consortia differed across sites with regard to the extent to which participants were enabled to occupy “diverse and meaningful roles” within the organization. As indicated in Table 3, most of the consortia examined included subcommittees, which typically met monthly or quarterly and afforded program participants, community members, providers, and other stakeholders an opportunity to participate in the ongoing work of the organization. In Pittsburgh, participation included consortium members playing a genuine role in establishing funding priorities, developing program plans, approving media campaigns, and even helping in the development of advertisements. In Chicago, consumer and community members were involved primarily through the consortium’s Community Mobilization Committee, decid-

ing and acting on their own program agenda and sometimes catalyzing change efforts in the full consortium as well.

Opportunities provided for consortia members at several sites included having active input in the grant application process and in decision making about budget cuts. In New Orleans, for example, a strategic planning process focused grassroots participation on measurable outcomes for reducing infant deaths, increasing high school completion, lowering violent crime, and achieving other objectives. Community-based organizations that devised plans that would specifically advance one of their strategic goals then were granted \$10,000 partner minigrants. Reflecting back on the importance of this process, one staff member commented that “the strategic planning process marked the first time board members sat down with consumers and understood that their voice is just as important—an equality emerged and was noticeable.”

Despite these positive examples of the provision of opportunities for meaningful role occupancy, considerable room for improvement also was observed. For instance, several sites had failed to get program participants on their steering committees or board of directors, often despite considerable efforts to do so. At other sites, power imbalances resulted in community-based organization (CBO) representatives and other providers driving the decision-making process, even when consumers were technically in positions to have more input. Addressing such problems is critical, because as Gruber and Trickett³³ have suggested, organizational structures that appear empowering yet fail to provide members with real decision-making power may, in fact, undermine the prospects for true empowerment.

As indicated in Table 2, consortia members at most sites appeared to have input in policy decisions affecting things such as the type and level of services. Yet, with the exceptions of Pittsburgh and to a lesser extent New Orleans (see above), they generally did not have input in budget and personnel decisions. As Plough and Olafson¹⁷ noted in their early case study of Boston’s Healthy Start experience, “sharing power was the major challenge” (p. 229), and both Howell et al.’s¹⁵ evaluation and our study findings attest to the continuing difficulties faced in this arena. As suggested above, however, our findings also indicate that on balance, most sites were highly committed to, and making real progress in, finding creative ways for increasing participant involvement in a diverse array of meaningful roles within the program.

Support system fostering social identity and peer support. Evidence of the development of a support system fostering social identity and peer support appeared to differing degrees and in different forms in each Healthy Start site examined. New York City staff and program participants thus remarked on the role that consortium members and program consumers played in recruiting new members both as clients and as participants in the consortia and related program activities. Whether through writing an article about Healthy Start for a neighborhood newspaper, serving as peer educators on domestic violence, or simply spreading the word by recruiting friends and neighbors, program participants and consortia members at this site were credited by staff with having brought in many new program attendees. In Cleveland, the fact that the graduates of one of Healthy Start’s early community outreach training programs went on to form their own group, the Cleveland Neighborhood Forum, which came together bimonthly and also met with other neighborhood groups within and outside the city’s borders, provided another example of the social identity and peer support fostered through the program.

Finally, and in keeping with Fawcett et al.’s⁶ emphasis on removing social barriers as a critical strategy for empowerment, several consortia made conscious efforts to broaden or

deepen sense of community across lines of race/ethnicity, class, or professional hierarchy. Philadelphia's consortium, for example, was concerned that it was not adequately reaching into the Asian American community and consequently formed an Asian Advisory Committee, which later became part of the health department. Similarly, this Healthy Start recognized early on the lack of trust among provider members of the consortia and held a daylong event to attempt to build community within this segment of the consortium. As noted in Table 2, while tensions based on race, class, and professional hierarchy emerged as a theme at many of the sites, so did efforts to address these tensions and in the process to build a more inclusive social identity.

Collaborative leadership. The nurturing of collaborative leadership through the consortia also was apparent to different degrees across sites, as highlighted in several of the study themes identified. Opportunities for such leadership thus were discussed in terms of community capacity building, the heavy accent placed on training community members for leadership roles, and stories of success. In the latter regard, a young woman in Chicago described how she had been helped through the program to develop leadership skills and move from being a program participant to the chair of her site's active Community Mobilization Committee.

Pittsburgh had a clearly demonstrated commitment to shared power between the grantee and the consortium, with some community members active since the program's inception and displaying a real sense of ownership. One focus group member thus described how she carved out a role for herself in the early planning process, stating that "I just came to the table and started demanding what I wanted for my community . . . and I've been here ever since." New Orleans recently had added two consortium members to the board of its nonprofit, the Great Expectations Foundation. In the focus group, both of those young women were able to answer tough questions raised by the group on why certain administrative decisions had been made by Healthy Start, and both demonstrated their clear identification with, and involvement in, the program's policy-making processes.

In Cleveland, collaborative leadership was emphasized through both the regional and the overarching Consortia Leadership Committee, which included program participants, business and community leaders, clergy, and program staff who meet regularly to discuss program planning and implementation. In the words of the consortium chair, "The key to developing community leadership is honoring the community's voice. That doesn't mean just giving people honorary status at the table but real decision-making power."

Elsewhere, we examine in detail the facilitators of, and barriers to, the effective functioning of Healthy Start consortia.⁹ As suggested above, however, and despite substantial variation by site, each of the Healthy Start programs examined had evolved consortia that appeared to meet several of the basic criteria for empowering organizations.

Healthy Start Consortia as Empowered Organizations

As noted earlier, empowered organizations have been defined as those that successfully develop and compete for resources, influence policy decisions, and/or offer effective alternatives for service provision.²⁰ The diverse Healthy Start consortia examined in this study were at very different places in terms of the extent to which they could be considered truly empowered organizations. Yet, with the exception of Kansas City, whose consortium was still in the early stages of its evolution, each of the consortia had met to

different extents the criteria of empowered organizations, and all appeared committed to further movement in this direction.

Successful growth and development. Each of the eight original Healthy Start sites examined had developed consortia that evolved considerably in their organizational development and perceived effectiveness. In Pittsburgh, consortium meeting dates were scheduled 1 year in advance, and twice-yearly trainings, the production of dictionaries on prenatal care and managed care, and other means were used to facilitate active growth and engagement of consortia members.

Healthy Start in New York City was initially brought to Harlem through a group of volunteers who convinced the Urban League to begin a prenatal network. The Harlem site originally provided an informal mentoring role to the two other program sites (Brooklyn and the Bronx), and today, although the three sites continue to operate fairly autonomously, they have begun coordinating more closely through a regional consortium.

The Philadelphia consortium's development path was probably the most unusual examined, with the consortium having become so "empowered" a few years ago that its leadership made serious efforts to separate from the grantee agency and negotiate directly with the federal government to establish an independent agency. With technical assistance provided by an outside team of community builders, the program was helped to transition through this difficult phase to a new and well-functioning structure in which the Healthy Start program allocates funds to an activist community organization that operates the consortium.

The development of new nonprofits occurred at three sites (New Orleans, Pittsburgh, and Pee Dee). As discussed elsewhere,⁹ however, such growth often faced serious obstacles. In Pee Dee, for example, the decision to form a separate 501c3 resulted in a strong African American-led organization but also resulted in the loss of some support from the mainstream white community as white members of the board dropped their membership in the transition. Yet, despite such obstacles, the very development of new Healthy Start nonprofits constituted important and tangible evidence of the development of empowered organizations.

Effective competition for resources. This was demonstrated at a number of the sites examined in this study, with many consortia generating goods and services, as well as financial contributions, from local businesses and agencies in support of their events and activities. New Orleans's new Healthy Start nonprofit proved adept at generating new funding streams, while the Pittsburgh and New York City programs consistently sought alternative funding to continue their male involvement projects after early funding cuts by HRSA. Consortia members at these sites insisted that men were too important to the lives of the children to have this component dropped and turned their attention to finding other funding sources.

Where the consortia had considerable overlap with economic development leaders in their communities, new funding streams were developed with particular attention to improving infant and family health. But the consortia also showed creativity in attaining needed resources in other ways. When New York City Healthy Start learned that its budget would be decreased as a result of national program expansion, it set about including in its upcoming leadership training an emphasis on how to write small grant proposals and in other ways work toward sustainability. Similarly, when Boston Healthy Start was faced with budget cuts, it provided a consultant to help 20 of its subcontractors arrange for alter-

native funding to ensure their viability. In both of these instances, the consortia actively assisted in decision making aimed at building and strengthening capacity at the local level.

Offering effective alternatives for service provision. Each of the Healthy Start consortia examined played an important role in relation to Fawcett et al's⁶ strategies of removing social and environmental barriers and enhancing environmental supports and resources. When Cleveland outreach workers noted the displacement of pregnant women from housing due to gentrification in the central city, they came to the consortium to devise focused new housing partnerships that could find families emergency and long-term affordable housing. When Pittsburgh's consortium identified as a top priority involving fathers more actively in their children's lives, it helped create an extensive male outreach and support program. In rural Pee Dee, consortium members saw the lack of regular public transportation as the most important barrier to families receiving regular medical attention. Together with program staff, they devised a supportive system of transportation, including the use of Healthy Start vans both to increase health care access and to enable community members to attend consortium meetings and other activities.

Partnering with a local hospital and a clinic, Pittsburgh's consortium also helped develop two residential programs for clients, while Kansas City Healthy Start and its consortium were instrumental in helping their city expand its teen pregnancy prevention program, KC WAIT, and engage multiple community partners in this effort. Indeed, at every Healthy Start site examined, we identified several examples of ways in which the consortia had contributed to the creation of new or modified programs or practices.⁹

Partnership or networking with other organizations. As indicated in Table 2, a theme identified by two of the three reviewers involved the extent to which the consortia had been able to create and sustain partnerships with both public- and private-sector organizations and entities. Although those Healthy Start programs that had close links with local or state health departments appeared to be particularly well positioned for such networking, virtually all of the project sites examined demonstrated such linkages. At many sites, as suggested above, local businesses contributed food and goods for health fairs, cosponsored special events, provided technical assistance, and assisted in fund-raising. In Cleveland, target area churches sponsored "Healthy Baby Sundays," in which part of a service was focused on increasing awareness about infant mortality. Both Cleveland and Chicago partnered with local jails, developing special programs for the growing number of pregnant and parenting women who were incarcerated.

Some Healthy Start consortia created strong alliances with key political leaders and the local media. The mayors of both Cleveland and New Orleans often played an active role in consortia meetings, and their very presence enhanced attendance and perceived organizational credibility. Philadelphia's program ran a lending closet for expectant and parenting women, in partnership with the office of the mayor. Kansas City's consortium appeared particularly adept at drawing on its political and media connections in educating policy makers and the general public about Healthy Start and in pushing for new funding streams and policy changes that would enhance service delivery.

At several sites, networking sometimes resulted in the creation of new citywide coalitions or other interorganizational linkages. New York City Healthy Start thus took the lead in forming a consortium of 20 to 30 male involvement programs that it convened on a monthly basis. This Healthy Start also partnered with the Children's Defense Fund and the local health department to undertake aggressive outreach on immunizations.

A critical result of consortia networking involved the fact that for the first time in many communities, non-health-related organizations were actively involved in the fight against infant mortality. Commenting on this increased involvement of local CBOs, one of Boston's consortium leaders commented that "more and more people are realizing that institutions aren't healthy if the community isn't healthy."

Influencing policy decisions. A major theme that emerged in our study involved the diversity across consortia, reflected in part in the very different extents to which they appeared to be involved in influencing policy within and beyond their Healthy Start programs (see Table 3). At many sites, the consortium, through its executive or steering committee, made policy decisions on the type and level of services to be provided but not on budget or personnel. In a few sites, major decisions concerning program direction were attributed by staff to advice from community members of the consortia. Boston staff members thus reported their site's development of a strong case management model heavily reflected community input, as captured in one woman's comment that

you don't need to give any more money to clinical services. You need to look at what's preventing people from getting to those services. We need baby-sitting, we need transportation. We need somebody who can take us through this whole process. . . . Don't just be interested in me while I'm pregnant.

Similarly, it was the community that decided that Boston's neighborhood health centers were the best venues through which to provide needed services.

As indicated in Table 2, however, a theme identified by two reviewers involved the often quite limited role of the consortia in influencing policy. In some cases, this appeared to reflect a lack of experience in speaking the language of policy. For example, some key informants and focus group members responded in the negative when asked whether their consortia had influenced policy yet later gave examples that were clearly indicative of a policy-influencing role. In many cases, however, the influence of the consortia appeared to be quite limited where policy was concerned—a finding that Howell et al.¹⁵ also reported.

At the same time, several impressive examples were provided of leadership by the consortia in efforts to influence policy at the macro level. Chicago's consortia, for instance, played a key role in both obtaining a statewide exemption for parents of special-needs children from work requirements under welfare reform and successfully mobilizing to stop a proposal to mandate Medicaid managed care on a statewide basis. In the latter case, the consortia were credited by some members as having given them the ability to critically analyze the effects of the proposed legislation on their community and to advocate against the proposed plan. In rural Pee Dee, consortia members and outreach workers enhanced environmental supports and removed an important social barrier by fighting successfully for increased access to health insurance among the area's growing number of part-time workers. As suggested above, however, such examples proved the exception rather than the rule in this study, and there was room for improvement in this area.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

As Green and Kreuter³⁴ and others^{1,3-6,35-39} have noted, the past two decades have seen a paradigm shift in thinking about prevention through which the community has become

the new “center of gravity”³⁴ in both scholarship and practice. The federal Healthy Start Program both reflected this trend and played a leadership role in demonstrating the role that well-funded community-based consortia could play as mechanisms for facilitating community involvement. Although it is still too early to attempt to link this program component with long-term changes in infant mortality and related health outcomes, it *is* possible to examine the intermediate outcomes of Healthy Start’s commitment to empowerment on the individual through the organizational and community levels. This article has attempted to contribute to this process by examining the ways in which the creation and nurturing of community-based consortia contributed to organizational-level empowerment at nine Healthy Start sites.

The development of consortia appeared to strengthen grassroots participation and focus institutional and organizational attention on the needs and concerns identified by local communities. By helping members identify and dialogue about the interrelationships between infant mortality and issues such as unemployment, domestic violence, and housing, the consortia helped to facilitate the development of critical awareness, which in turn served as a “catalyst for change” (p. 7)¹ as consortia sought to address some of these interrelated issues. Similarly, and although program staff and participants spoke of continuing tensions experienced around race, ethnicity, and class, the consortia at many sites helped address these tensions, through vehicles such as workshops on cultural competence and special outreach efforts. However, the needs for further work in this area and for providing a greater range of opportunities for resident participation in decision making and governance were apparent.

As Healthy Start transitions into its new role as a permanent program with a continued mandate for substantive community involvement, special attention should be devoted to providing greater guidance and support on this aspect of the program’s functioning. Based on our examination of the Healthy Start experience, some general implications for practice may be drawn with respect to the effective development, functioning, and sustaining of consortia as part of community-based health initiatives:

1. Roles for the consortia should be clearly laid out and should include identification of community concerns; strategic planning that addresses identified concerns; identification and recruitment of community institutions to partner in implementation; and ongoing outreach, monitoring, program development, and evaluation.
2. Support for the consortia should be substantial and should include high-level administrative personnel to support the operation of consortia; clear guidance and access to technical assistance (including peer mentoring) in the development, governance structure, functioning, and sustaining of consortia; and ongoing training for consortia members and leaders in governance, outreach, program evaluation, leadership, and advocacy skills.
3. The consortia should be helped to focus their membership on transforming programs, policies, and practices, rather than simply focusing on individual behavior change. One promising set of strategies that could be tried in this regard might include geographic mapping of factors in the community that affect health, analysis of mapping by diverse community stakeholders, identification of community institutions that can address priority factors, and developing community accountability for specific and realistic annual targets for reduction of negative factors.
4. Particularly in light of the growing national commitment to eliminating health disparities, consortia should be helped to analyze and develop plans to address racial

disparity in health outcomes. Plans and implementation should address cultural competency of health care providers, ability to reach target population with services, specific analysis of health indicators by race and ethnic community, and interventions that address specific racial and ethnic disparities.

Consortia and other community involvement mechanisms are time-consuming and labor intensive, and they may sometimes slow progress toward the achievement of program goals.^{7,15,17,38-40} Yet, as this study has suggested, a heavy accent on community involvement may ultimately strengthen programs like Healthy Start by enabling a focus of community concerns and issues, fostering local leadership, building strong community partnerships, and increasing a sense of local ownership.

Further research is necessary to determine how and to what extent empowerment at the individual, community, and organizational levels may be able to influence health outcomes.^{1,2,5-7,20,39-41} Yet, while this research is being undertaken, the many lessons learned through the Healthy Start experience with community involvement should be used to inform our practice. Together with prior research,^{1-7,17,19,37,40} this study has demonstrated that community involvement can make a real difference in helping to build organizational and community infrastructure. Through this process, it can transform programs, practices, and policies in ways that may lay important groundwork for the ultimate goals of changing health behaviors and health outcomes. Indeed, as former NHSP Director Henry Spring⁴² has pointed out, Healthy Start is a classic example of a health program that recognizes and “speaks to the pyramid” of community involvement and community capacity building as necessary building blocks for the achievement of distal health outcomes. This study suggests that by contributing to the intermediate level of the pyramid through organizational empowerment, the increasing emphasis on community involvement in comprehensive health initiatives like Healthy Start is well placed.

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