# Community Mobilization and Its Application to Youth Violence Prevention

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**Abstract:** In addressing health and social issues, there has been a shift since the 1990s to approaches that focus more on making comprehensive community-based changes to affect individual behavior. This article provides an overview of community mobilization to engage community members in the process of addressing social and health issues, discusses current models, and provides a case study. The balance of the article looks at other efforts reported in this supplement, and the ways in which they have used community mobilization as a viable strategy for preventing youth violence.
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## Background

Community-based approaches that engage community members in tackling community issues are becoming increasingly important in disease prevention and health promotion initiatives.[1–5] Community-based approaches have addressed adolescent drug and alcohol use,[6,7] smoking,[8] adolescent pregnancy,[6,9] and crime and violence.[10] Community mobilization and participation strategies facilitate a broader, collective response to community-defined social and health needs and give communities an effective voice in program delivery, service, and policy.[11] A critical determinant of success is the degree to which community members, groups, and organizations are mobilized to participate and collaborate in addressing community social and health issues.

## Overview

This article explores community mobilization and its impact on youth violence prevention outcomes. In particular, it focuses on community mobilization as an increasingly important strategy, providing the framework to encourage participation, cooperation, and collaboration for the "common good."[12] A brief review of the history of community mobilization approaches to health and social issues is followed by presentation of several models and critical organizing concepts, drawn from literatures in community development, health promotion, crime prevention, community based research and interventions, and community organizing. A case study next illustrates the application of community mobilization to youth violence prevention. Finally, the paper considers other community mobilization efforts and discusses implications for research and practice to enhance community mobilization as a strategy for preventing youth violence.

## Community Mobilization

The concept of "community" is broad and varies by discipline (e.g., psychology, sociology, public health) and by emphasis of prevention/intervention initiatives (e.g., targeting neighborhoods, entire cities, or particular social or cultural groups). One broad definition of community used in the social science and public health literatures[13–15] refers to people who share a concern, geographic area, or one or more population characteristics (e.g., culture, age).[16,17] The inclusion of community in these literatures represents a shift in theory and practice, from addressing individual and single causative agents of health and social issues to addressing psychosocial and sociocultural factors and their interactions.

Community mobilization is broadly defined as individuals taking action organized around specific community issues.[18] Grounded and guided by the seminal works of Cloward and Ohlin,[19] Alinsky,[20] Arnstein,[21] and Freire,[22] early community mobilization efforts attempted to view the individual in relationship to the community (e.g., family, neighborhood) to better understand the interplay of individual characteristics, health conditions, and environmental factors. It was not until the 1990s, however, that researchers and specialists increasingly applied community mobilization approaches to public health issues.

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Informed to a large extent by the literatures on community empowerment,[23–25] community participation,[26,27] capacity-building,[28,29] community coalitions,[4,30] and community organization and development,[31,32] community mobilization offered support for non-individualized, community-based strategies to improve health outcomes.

This shift was evident in the international arena where the concept of community mobilization relies considerably on the "new health promotion" philosophy and the practice of "enabling people to increase control over and to improve their health."[33] In this context, community health emphasizes a socioecologic approach that requires broad-based changes in the social and economic environment to improve health. Thus, by focusing on community mobilization and engagement, the "new health promotion"[34] movement shifted the focus of theory and practice away from individual lifestyle behavior change to social determinants of health.

In local communities in the U.S., organizations and citizen groups have rallied around concerns such as substance abuse, crime and violence,[10] HIV/AIDS prevention,[35,36] and at-risk adolescents. These projects, focused on the socially excluded, are grounded in the community development philosophy of mobilization, participation, and empowerment. Approaches that aim to mobilize and empower communities to identify their own health needs and facilitate ways to address those needs thus have gained wider acceptance in public health.[22,37]

## Community Mobilization Approaches and Models

Scholars characterize the relationship between researchers and communities in two ways: top-down (led by experts) and bottom-up or grassroots (community-driven). The top-down approach has the advantage of bringing outside expertise (e.g., researchers) to determine the prevention or intervention strategies most likely to be effective in addressing community health and social issues. A top-down approach, however, can fail to obtain the knowledge, involvement, and support of community leadership, especially the true concerns, interests, and social and cultural structures of a community. In contrast, the bottom-up or grassroots approach has the advantage of including a wide spectrum of community members and institutions in efforts to reduce community-identified problems. Community members, however, may not have the expertise to design and implement effective strategies to address those problems. Yet these two broad approaches are not mutually exclusive and may be better characterized as a continuum. Community mobilization approaches bring about change both by bringing resources into the community and by mobilizing or reorganizing existing community assets.

In community mobilization, researchers and community members together identify the causes of problems to determine whether they are internal or external, and assess community resources to determine if any additional resources are needed to facilitate change. These key issues guide the relationships and roles of participants, the type of information they acquire, the level at which change is addressed (e.g., system versus individual), and program delivery and policy implications. In all community mobilization approaches, a process of research, education, and action encompasses a broad partnership of individuals and groups. Four community mobilization models currently in use in the social sciences and public health are participatory action research, community-based participatory research, collaborative betterment, and community empowerment.

### Participatory Action Research

Participatory action research (PAR) has evolved since the 1970s. Its earlier work focused on community development in emerging nations, and was used later as a way to address issues challenging disadvantaged communities in industrialized nations.[38] For example, ethnic minority students' involvement and interest in their own community needs eventually led to the formal institution of ethnic studies programs across the nation.[39]

Participatory action research is a systematic investigation of social and health problems that actively involves disadvantaged communities through a collaborative process of research, education, and social change. A key element of PAR is the relationship between researchers and community members, in which researchers provide specific research skills and community members provide resources and knowledge about the community. Through a reciprocal transfer of knowledge, skills, capacity, and power, researchers and community members attempt to solve problems together. This partnership generates new knowledge (e.g., community-identified issues and analysis) and solutions (e.g., policy change, service delivery) that can raise consciousness and effect change.[40,41]

### Community-Based Participatory Research

One of the most common approaches to research and intervention in public health is community-based participatory research (CBPR). This approach, with roots in international participatory action research and social justice movements of the 1970s and 1980s, has been used more recently in public health to address health inequalities. Similar to PAR, CBPR is based on a collaborative process of research, education, and action, where researchers provide tools by which community members identify health needs and community members provide meaningful information about the community to researchers.

Where PAR focuses more on individuals in a community, CBPR is a systemic approach that empowers individuals and groups. It is a collaborative effort by all partners (researchers, community, and organizational members), in which each contributes his or her strength to the integration of knowl-

edge and action, to improve community-identified health concerns. All partners are involved in all phases of the research process: planning, data collection, analysis, and dissemination.[5] Through their participation, a shift in community members' understanding of health occurs, from one that emphasizes reliance on the health-care system to one in which health is seen as a resource that comes from the community. The understanding and approach of researchers also shifts, from interventions that target the micro level to those targeting the macro level.

## Collaborative Betterment Model

The collaborative betterment model (CBM) uses a top-down approach to address community health problems. Under CBM, large public, private, or nonprofit institutions (e.g., universities or government agencies) initiate and form coalitions with communities to address community health needs. Those external organizations, rather than community members, generally guide and control the process. Although community representatives, in advisory roles, may inform the design of action plans, they are generally excluded from decision making and resource allocation. Thus, CBM is not necessarily designed to transfer power or ownership to communities, but rather to deliver services and programs. Nevertheless, community building and service and program delivery do occur and, in the process, coalitions contribute "better practices" for addressing community health needs.[42]

## Community Empowerment Model

The community empowerment model (CEM), similar to CBM in concern for community building, service and program delivery, and policy advocacy in addressing community health concerns, differs in the way institutions and communities relate to community organizing, leadership development, power, and ownership. Rather than serving as "objects" of research and intervention, community representatives are "subjects" of their own research and intervention. Thus, they serve to enhance their community's capacity to establish goals and to control resources to address health challenges. Under CEM, communities initiate the coalition process through community organizing, and community representatives can assume power and control over the mission, decision making, and action plans. Institutions outside the community generally provide support to the coalition's goals, but do not play a primary role. The process, then, is guided and controlled by community representatives and not institutions outside the community.

Although these community mobilization models vary in the relationship between researcher and community, they are not mutually exclusive. For example, Himmelman[42] maintains that CBM and CEM can serve as

guides to the coalition process between institutions and communities. A critical aspect of community mobilization models is that community members become involved in a social process whereby community needs are addressed through social action.[43–45] Partnership building highlights the idea of communities as social networks and social ties and is integral to the construct of social capital.[46] Partnerships may take several forms: (1) Strategic partnerships involve the development of policies, the understanding of problems and issues, and the shaping of the political will to tackle these problems and issues; (2) Tactical partnerships involve establishing committees and developing legislation, targets, budgets and resources to deal with issues; and (3) Operational partnerships focus on action. The structure of partnerships can vary and may include formal organizations as well as individuals and grassroots organizations that have formed around a recent event or an ongoing local concern.

Community mobilization, considered the first step in community organization and development, is based on the premise that active participation of community members and groups will lead to greater effectiveness and efficiency in addressing problems.[47] Central to this concept is emphasis on (1) community building and social capital to foster positive connections among individuals, groups, neighborhoods, and organizations, and (2) empowerment-based interventions to strengthen the norms and problem-solving resources of the community.[46] Thus, community mobilization operates on the basis of a coordinative process to address community health concerns.

This interactive process includes several stages that bring people together to address community health issues. The first stage—preparing the ground—involves the creation of a steering group to explore community issues. This includes setting priorities during initial planning, making contact with relevant community groups and leaders (both formal and informal), and identifying available resources and a management structure. The next stage—developing capacity—builds capacity for strategic planning, interpersonal communication, and group processes. The third stage—assessment—consists of assessing the needs and issues most important to the community. The fourth stage—implementation—involves performing targeted community interventions to foster behavior change. The final stage—evaluation—focuses on documenting the progress, identifying barriers to progress, and redirecting efforts to activities that may be more effective.[48]

## Community Mobilization and Youth Violence Prevention

Youth violence is defined as an act—intentional, actual, or implied—against oneself or another person, group, or

community that leads to injury, death, or psychological harm,[49] in which individuals—perpetrator or victim—are 10–24 years old.[50] Although youth homicide rates have declined in recent years, homicide is the second leading cause of death for people in this age group. In fact, nearly 48% of homicides in the U.S. in 2000 were committed by individuals under age 24. Among ethnic minorities, homicide is the leading cause of death for African-American youth, second for Hispanic-American youth, and third for American Indian and Alaska Native youth and Asian Pacific Islander youth.[50] Of the 5486 youth homicides reported in 2001, 85% involved males and 15% involved females.[50]

Research has identified four levels of risk factors for youth violence: individual (e.g., poor behavioral control, low IQ); familial (e.g., family violence and conflict, lack of parental involvement); peer/school (e.g., poor academic achievement, gang involvement); and community (e.g., community violence and lack of social cohesion within a community).[49,50] Several protective factors (individual or environmental) can serve to buffer risks of violence, including high IQ, positive social orientation, intolerance toward deviance at the individual level, and commitment to school and social engagement at the peer/school level. Because youth violence is a complex public health issue that affects the whole community and involves multiple risk and protective factors at multiple levels, changing it requires an ecologic, interdisciplinary approach (e.g., medicine, epidemiology, education, psychology) that emphasizes the collective action of various sectors (e.g., health, social services, education). Such change further requires a scientific method that enables researchers to identify the causes and consequences of youth violence systematically and design intervention programs to create environments that allow for health and development.[49]

The community mobilization approach affords great capacity to understand and identify risk and protective factors at multiple levels, to prevent and reduce youth violence, and to create safe communities using empirically supported programs.[51] For example, researchers can identify risk factors that may be related to an individual being a victim or perpetrator of violence (individual level) and how exposure to violence through the individual's relationships with peers and family members can lead to repeated abuse by the perpetrator (family or peer level).[52] Further, identifying links among different types of violence (e.g., suicidal behavior and child maltreatment) can reduce these types of violence for youth.[53,54]

Community mobilization also offers youth violence research the potential for a comprehensive strategy to support and facilitate the integration of community participation and collaboration, both in preventing youth violence and in building safe, healthy, and peaceful communities.[55] Public health approaches to youth violence characterize three levels of intervention: primary (preventing violence before it occurs), secondary (reducing risk factors associated with violence), and tertiary (reducing negative effects stemming from violence).[56] Community mobilization approaches can be designed to address all three levels, and thereby facilitate a move from the punitive model of the judicial system to a model based on strength.

Community mobilization approaches to youth violence prevention can also facilitate the development of culturally appropriate and sensitive interventions. Although violence affects all youth, an increasing number of ethnic minority youth are being directly or indirectly affected by violence.[50] Community participation in program initiatives is traditionally low among disadvantaged or underrepresented groups.[57] Researchers have identified several barriers to community participation, including poorly designed services,[58] lack of trust of health services, and language barriers.[59] More culturally specific and sensitive strategies to address these barriers can represent the concerns of the community, especially if the representation reflects the community's diversity.[60]

## Case Study: East Bay Chinese Youth Council

In Oakland's Chinatown in 1967, approximately 28 youth between the ages of 15 and 18 formed a group called Oakland Suey Sing Boys.[61] They were motivated by their need for a place to "hang out" and to protect themselves from rival Oakland groups. One strategy to ensure their safety was to ally with another gang, from the San Francisco Suey Sing Tong. As the Oakland Suey Sing Boys group developed, it faced challenges from other groups (e.g., the Chicanos at Oakland Technical High School and The Rickshaw Runners, an Oakland-based American-born group of Chinese and Japanese youth). In 1968, the Suey Sing Tong recruited many gang members into their group in an attempt to control rising youth crime and violence.

In August 1969, a diverse group that included the Oakland Suey Sing Boys, the leader of the San Francisco Suey Sing Tong, and high school and college students founded the East Bay Chinese Youth Council (EBCYC) in Oakland's Chinatown. The early organizational meetings were held in the Chinese Presbyterian Church, where members and associates, most of whom were American-born Chinese college students, desired a progressive voice in the Oakland Chinatown area. In March 1970, EBCYC became an incorporated nonprofit organization. As a result, many college students were paid from college work-study funds, and received internship credit, and a handful were hired as Field Work Assistants by the University of California, Berkeley, Asian American Studies Program. By 1971, the EBCYC staff numbered close to 45 people, ranging in age from 15 to 29. Most were volunteers and included high school students, gang members from the Suey Sing Boys, community members, and college students.

One of the original goals of EBCYC was to assist Chinese youth through education, recreation, social services, and employment opportunities. As EBCYC developed, its goals became more refined and focused on (1) increasing funding and social services to East Bay Asian American youth (e.g., the Oakland Chinese immigrant youth); (2) providing opportunities for youth to serve other East Bay Asian American youth; (3) developing leadership among the youth; and (4) empowering the local Asian American community. Fundraisers, private donations, and small grants supported a number of programs.

From 1969 to 1972, a broad range of programs were developed to support EBCYC's goals, including (1) a bilingual tutorial and counseling program at Lincoln Elementary School, Westlake Junior High School, Oakland Technical High School, and Oakland High School; (2) a monthly Asian film festival; (3) a People's Service (e.g., community clean up, legal aid, draft counseling); (4) an annual community festival; (5) a job-referral program; (6) a health survey/referral program; (7) a youth field trip recreation activities program; and (8) a community school for Chinese immigrant newcomers, accredited by the Oakland School District. Many of these programs were under the umbrella of EBCYC's Summer War on Poverty Neighborhood Youth Corps program. This 10-week summer program employed over 600 Oakland youth (14–18 years old) for 26 hours per week, from 1970 to 1972. The programs were run out of the EBCYC office in Oakland's Chinatown. Important community partners, in addition to the Presbyterian Church, the Suey Sing Tong, the Oakland Public School District, and the four aforementioned schools, included the Chinese American Citizens Alliance, Oakland Chinese Community Council, and the Lincoln Park Recreation Center. The EBCYC played another noteworthy advocacy role for Asian American youth, by being instrumental in increasing social services for Asian American youth. For example, the organization urged the Oakland School District and its funding organizations to implement bilingual/bicultural programs for children who spoke an Asian language.

In late 1972 and early 1973, conditions spurred EBCYC to transition into a broader organization, East Bay Asians for Community Action (EBACA). Although still focused on youth and the Chinese community, the council also wanted to include other age groups and other Asian Americans. (Although EBACA existed for only two years, one of its subprojects, Asian Health Services, is still operating in the heart of Oakland's Chinatown.) A major factor in EBCYC's transition to EBACA was gang members. Younger gang members were motivated more by the hope for "easy money" through the organization than by bringing about community empowerment. At one point, the major San Francisco Chinatown gang leader, who had been employed as a San Francisco gang outreach worker, initiated a hostile takeover of the EBCYC club house,

programs, and staff. Although he successfully recruited new Suey Sing Boys and their friends, he was rebuffed by older members of the Oakland Suey Sing Boys, who had been involved with EBCYC. Due to the positive influence of EBCYC, the older gang members did not want to get involved with him. In response, the older gang members, the EBCYC Board of Directors, and the staff were instrumental in creating the new organization, EBACA.

Involvement in EBCYC and EBACA had a profound impact on the Oakland Suey Sing Boys. For example, many older members adopted principles consistent with the founding college students and became concerned with improving the life and community of Chinatown. They also influenced new members by encouraging them to participate in programs such as the Summer War on Poverty Neighborhood Youth Corps. Follow-up interviews after the young people became adults showed that 20 of them married and had children, and 17 live in the greater San Francisco Bay area with successful professional and personal lives. Seven own and operate businesses (one is a well known chef in New Orleans) and nearly 20 are employed in occupations such as hairstylists and auto mechanics. Although four members continued using drugs and two committed serious crimes, interviews revealed that none of them wanted their children to be involved in gangs.

Involvement as members of the EBCYC leadership and staff proved to be an important training ground for future leaders. Many still work and live in the Chinatown area. For over 30 years, they have played important roles in the public and private sectors, becoming civil rights attorneys, businesspeople, and educators. One former Neighborhood Youth Corps worker has been in the Asian Health Services for over 15 years.

This case study, illustrating community mobilization efforts and youth violence, presents several lessons. First, as was the case with the Oakland Suey Sing Boys, gang formation is not simply a product of greed and irrational deviant behavior, but rather a function of youth members seeking protection from harassment and discrimination. Recent studies have shown that gangs can play a role in protecting individuals from harassment or buffering negative experiences with out-group members.[62,63] Second, youth violence is partly influenced by other gangs and can lead to an increase in gang activity within a community. Although the Oakland Suey Sing Boys functioned as a gang prior to their connection with other groups, they were acknowledged as a gang only after they became affiliated with larger groups. To tackle youth violence, researchers must examine patterns of gang development and their proliferation across urban areas.

Community organizations can influence the directions that gangs take. This was seen in the development and demise of the Suey Sing Boys, who were influenced

by a number of different organizations in the Chinese community, particularly EBCYC. Thus, researchers should continue to investigate gangs and their activities as well as the broader social networks[64] in the community and the types of services and opportunities available to disadvantaged groups.

Elements of participatory action research (PAR) and the community empowerment model (CEM) can be seen in the community mobilization efforts in this case study. This was a community-driven, bottom-up approach in which leadership and core staff were primarily college students, with none under the direct or indirect supervision of university faculty. Most came from the Asian American community and half were bilingual in Cantonese and English. Consistent with PAR, EBCYC investigated social and health problems by actively involving area youth through a collaborative process of research, education, and social change. The organization's structure provided investigative research opportunities at the Board of Director, staff, and project levels. The EBCYC also employed major elements of CEM. Close attention was paid to community building, service and program delivery, and policy advocacy in addressing community concerns. For better or worse, the community-based EBCYC controlled its own mission, goals, objectives, action plans, and ultimately its own destiny. By paying attention to the lessons described above, researchers and community members can bring a more comprehensive and culturally sensitive approach to their mobilization efforts to reduce youth violence and build safe and healthy communities.

## Community Mobilization and Contemporary Youth Violence Prevention Efforts

Several of the articles in this supplement[65–72] describe a variety of approaches to mobilizing communities to prevent or reduce youth violence. Definitions of community vary, as does the subject matter addressed and the mobilization approaches employed. These differences are attributable to the nature of the concerns being addressed, the structure and dynamic of the community in which the work is performed, and the philosophical perspective of those engaged in mobilization. At the same time, common themes can be found.

One area in which differences are readily apparent is the definition of community. In some initiatives, the parameters of the community include the entire city or locality,[65,66] whereas other mobilization efforts have targeted specific neighborhood or housing projects,[67–70] or even specific blocks within a neighborhood.[71] Many community mobilization efforts have employed user-friendly research methodologies such as PAR and CBPR to inform the process and empower the target community, by conducting assessments of community needs and strengths.[65,71]

Consistent with CEM, many of the mobilization efforts recruited community residents to collect and analyze information that would form the basis for their action plans. For example, in Riverside, California, residents conducted an "asset mapping" survey to understand available neighborhood assets and the uses of these assets to foster neighborhood mobilization and revitalization.[68] In San Diego, residents were recruited as hosts, willing to convene other residents to assess communities and identify potential leaders for the mobilization effort.[72] In Richmond, geo-mapping was used to assist residents in demonstrating the relationship between the incidence of violence and areas where certain alcoholic beverages were sold in convenience stores, for presentation to a regulatory body.[65]

The collection and analysis of qualitative data has also been used to evaluate the impact of mobilization efforts. The organizational empowerment project in Flint[66] and the Constructing Peace project in New York City,[67] designed to help youth cope with the aftermath of 9/11, both employed ATLAS.ti methodology to analyze themes related to project goals.

Several community mobilization projects not only acknowledged the importance of sensitivity to cultural differences and influence but also incorporated components of the target community's culture into their programmatic strategies. The Hui Malama o ke Kai project in Hawaii[70] and the violence prevention partnership development project in Puerto Rico[69] intentionally employed values and customs of the indigenous culture to foster youth and community development.

The diversity of mobilization approaches described in this supplement provides an opportunity to examine the implications of how community is defined and which strategies are employed. For instance, the broader community efforts in Flint and Richmond have the potential to affect large segments of the community. At the same time, the scope of these efforts makes it more likely that representatives from organizational and governance sectors will play key leadership roles in the mobilization effort, and more difficult to involve large numbers of local residents. Even when organizers are able to successfully engage youth, as the Flint program did, these individuals serve more as representatives of their broader constituency group than as agents of change in their own neighborhoods. The Mid-City Community Advocacy Network Project in San Diego was able to overcome this obstacle, in part, by organizing smaller collaboratives through the house meeting mechanism, in which hosts each recruited 10 neighbors from their block to participate in discussions about initiating a community engagement project.[72]

Mobilization efforts directed at specific neighborhoods and other small geographic areas can more readily develop and implement comprehensive strategies for engaging and empowering communities. Although the process requires considerable time to ma-

ture fully, tangible results may be seen more quickly in efforts targeting smaller, discrete geographic areas.

A common theme in most of the programs described in this supplement is the importance and complexity of establishing an effective relationship between academic and community partners.[65,67,68,70] This challenge is made more daunting when academic and community partners are of different cultural backgrounds. Suggestions for building trust include: (1) explicitly acknowledging differences and conflicts between researchers and administrators/elected officials[68]; (2) creating a common vision and shared meaning through active engagement and the development of consensus[67]; (3) demonstrating commitment of the university by giving back to the community through membership on boards and community services[70]; and (4) establishing a shared expectation that effective mobilization requires a long-term commitment.[70]

Most of the authors in this supplement have explicitly expressed their intention to engage and empower community stakeholders through the mobilization process. The extent to which the relationship becomes genuinely bilateral and actually results in increased ownership and competence by community participants will be determined as much by the specific aims, structure, and process adopted by those organizing the mobilization effort as it will by the stated philosophical perspectives of the university and community stakeholders. For example, the Hawaii, Riverside, and Kansas activities[68,70,71] recruited local residents as the primary agents of mobilization and used governance structures composed of community residents to determine how to implement the mobilization process. These geographically targeted, citizen-led approaches model and support empowerment.

Finally, the process of mobilization seems to be facilitated by use of a developmental framework. Examples of these frameworks include the Institute of Medicine model used in Kansas[71] and the Communication for Social Change Model employed in Puerto Rico[69] to foster the development of partnerships to (1) assist police in their efforts to improve relations with community residents, (2) empower residents to improve the environment in which they live, and (3) establish a human service infrastructure to complement law enforcement activities.

## Conclusion

Community mobilization is the first step in engaging individuals and organizations to address community social and health issues collectively and to direct action toward changing adverse social conditions affecting individuals, communities, and public health. Successful use of community mobilization relies on several underlying factors, especially in terms of collaborative partnership: (1) The goal cannot be reached by any one individual or group working alone; (2) Participants include a diversity of individuals and groups who represent the concern and/or geographic area or population; and (3) Shared interests make consensus among the prospective partners possible. For these reasons, the community mobilization approach facilitates cultural appropriateness, wide reach, and a great sense of community ownership of the intervention in the process of addressing immediate social and health concerns and creating safer social conditions. It should be noted that community mobilization is time-intensive, process-oriented, and complicated, in part, by the number of individuals and organizations involved. Our own example of EBCYC illustrates how conflicts between organizations or key community leaders can lead to complications and reduce effectiveness. Some researchers and practitioners may be reluctant to work with individuals and organizations in communities. However, community mobilization is an important tool that can be used by Violence Prevention Centers such as those described in this supplement to show a new generation of young individuals the importance of research and education in bringing about social change. Ultimately, individuals who blend community and research may lead the "new health promotion" field that attempts to integrate the strengths of community and research, and rely less on medical models that attempt to identify the root cause of behavior by focusing on and treating the individual in isolation from the community.

## References

1. Hawkins D, Catalano R, Miller J. Risk and protective factors for alcohol and other problems in adolescence and early adulthood: Implications for substance abuse problems. Psychol Bull 1992;112:64–105.
2. Rog D, Bobacka N, Barton-Villagrana H, et al. 2004. Sustaining collaboratives: a cross-site analysis of the National Funding Collaborative on Violence Prevention. Eval Program Plan 2004;27:249–61.
3. U.S. General Accounting Office. Community-based drug prevention. Report to the Chairman, Select Committee on Narcotics Abuse and Control, House of Representatives, Washington DC. 1992.
4. Gilles P. The effectiveness of alliances and partnerships for health promotion. Health Promot Int 1998;13:1–21.
5. Israel BA, Schulz AJ, Parker EA, Becker AB. Review of community-based research: Assessing partnership approaches to improve public health. Annu Rev Public Health 1998;19:173–202.
6. Paine-Andrews A, Vincent ML, Fawcett SB, et al. Replicating a community initiative for preventing adolescent pregnancy: From South Carolina to Kansas. Fam Community Health 1996;19:14–30
7. Rowe W. Changing ATOD norms and behaviors: A Native American community commitment to wellness. Eval Program Plan 1997;20:323–33.
8. COMMIT Research Group. Community intervention trial for smoking cessation (COMMIT): I. Cohort results from a four year community intervention. Am J Public Health 1995;85:183–92.
9. Nezlek JB, Galano J. Developing and maintaining statewide adolescent pregnancy prevention coalitions: A preliminary investigation. Health Educ Res 1993;8:433–47.
10. Chavis DM. Building community capacity to prevent violence through coalitions and partnerships. J Health Care Poor Underserved 1995;16:234–45.
11. Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. Annu Rev Public Health 2000;21:369–402.
12. Park P. The discovery of participatory research as a new scientific paradigm: personal and intellectual accounts. Am Sociol 1992;23:29–42.

13. Haglund B, Weisbrod RR, Bracht N. Assessing the community: Its services, needs, leadership and readiness. In: Bracht N, ed. Health promotion at the community level. Newbury Park: Sage, 1990.

14. Jewkes R, Murcott A. Meanings of community. Soc Sci Med. 1996;43:555–63.

15. Newby H. Rural sociology. Curr Sociol 1981;1:1–141.

16. Fawcett SB. Some lessons on community organization and change. In: Rothman J, ed. Reflections on community organization: Enduring themes and critical issues.Itasca, IL: Peacock Publishers, 1999:314–34.

17. Smithies J, Adams L, Webster G, Beattie A. Community participation in health promotion. London: Health Education Authority, 1990.

18. Fawcett SB, Francisco VT, Hyra D, et al. Building healthy communities. In: Tarlov AR, St. Peter RF, eds. The society and population health reader, Vol. II: A state and community perspective.New York:New Press, 2000:75–93.

19. Cloward R, Ohlin L. Delinquency and opportunity: a theory of delinquent gangs. Glencoe, IL: Free Press, 1961.

20. Alinsky S. Rules for radicals. New York: Random House, 1971.

21. Arnstein S. A ladder of citizen participation. J Inst Plan 1969;35:216–24.

22. Freire P. Pedagogy of the oppressed. London: Sheed & Ward, 1972.

23. Fawcett SB, Paine-Andrews A, Francisco V, et al. Empowering community health initiatives through evaluation. In: Fetterman D, Kaftarian J, Wandersman A, eds. Empowering evaluation: Knowledge and tools for self-assessment and accountability.Thousand Oaks, CA:Sage, 1995:161–87.

24. Hanna MG. Strategies for community empowerment. New York: Edwin Mellen Press, 1994.

25. Kieffer C. Citizen empowerment: A developmental perspective. Prev Hum Serv 1984;3:9–36.

26. Bracht N, Finnegan JR, Rissel C, et al. Community ownership and program continuation project. Health Educ Res 1994;9:243–55.

27. Florin P, Wandersman A. An introduction to citizen participation, voluntary organizations, and community development: Insights for empowerment through research. Am J Community Psychol 1990;18:41–54.

28. Easterling D, Gallagher K, Drisko J, Johnson T. Promoting health by building community capacity. Aspen, CO: The Colorado Trust, 1998.

29. Hawe P, Noort M, King L, Jordens C. Multiplying health gains: the critical role of capacity-building within health promotion programs. Health Policy 1997;39:29–42.

30. Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion: factors predicting satisfaction, participation, and planning. Health Educ Q Res 1996;23:65–79.

31. Gittell M, Bockmeyer J, Lindsay R, Newman K. The urban empowerment zones: Community organizations and community capacity building. Institute monograph. New York: Howard Samuels State Management and Policy Center, 1996.

32. Minkler M. Community organization and community building for health. New Brunswick: Rutgers University Press, 1997.

33. World Health Organisation. Ottawa Charter for Health Promotion. Ottawa: Health and Welfare, Canada/Canadian Public Health Association, 1986.

34. Robertson A, Minkler M. New health promotion movement: A critical examination. Health Educ Q 1994;21:295–312.

35. Valdiserri RO, Aultman TV, Curran JW. Community planning: A national strategy to improve HIV prevention programs. J Community Health 1995;20:87–100.

36. Parker RG. Empowerment, community mobilization and social change in the face of HIV/AIDS. AIDS 1996;3(Suppl 10):S27–S31.

37. Shediac-Rizkallah MC, Bone LR. Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. Health Educ Res 1998;13:87–108.

38. George MA, Green LW, Daniel M. Evolution and implications of P.A.R. for public health. Promot Educ 1996;3:6–10.

39. Wei W. The Asian American movement. Philadelphia: Temple University Press, 1993.

40. Dalton J, Elias M, Wandersman A. Community psychology: Linking individuals and communities. Belmont, CA: Wadsworth, 2001.

41. Kidd SA, Kral MJ. Practicing participatory action research. J Counseling Psychol 2005;52:187–95.

42. Himmelman AT. On coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment. Am J Commun Psychol 2001;29:277–84.

43. Rosenstone SJ, Hansen JM. Mobilization, participation, and democracy in America. New York: Macmillan, 1993.

44. Treno A, Holder H. Community mobilization: evaluation of an environmental approach to local action. Addiction 1997;92(Suppl 2):S173–S187.

45. Bracht N, Kingsbury L. Community organizational principles in health promotion: A five-stage model. In: Bracht N, ed. Health promotion at the community level.Newbury Park, CA: Sage, 1990:66–88.

46. Joffres C, Langille D, Rigby J, Langille DB. Factors related to community mobilization and continued involvement in a community-based effort to enhance adolescents' sexual behaviour. Qualitative Report. 2002; 7(2). Available at: http://www.nova.edu/ssss/QR/QR7-2/joffres.html.

47. Putnam RD. Bowling alone: The collapse and revival of American community. New York: Simon & Schuster, 2000.

48. Fawcett SB, Francisco VT, Hyra D, et al. Building healthy communities. In: Tarlov AR, St. Peter RF, eds. The society and population health reader: A state and community perspective.New York: New Press, 2000:75–93.

49. World Health Organization. Geneva, Switzerland: Youth violence facts; 2002. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/youthviolencefacts.pdf.

50. Centers for Disease and Control and Prevention. Web-based injury statistics query and reporting system (WISQARS). Available at: www.cdc.gov/ncipc/wisqars/. 2004.

51. Coie NF, Watt SG, West JD, et al. The science of prevention: A conceptual framework and some directions for a national research program. Am Psychologist 1993;48:1013–22.

52. Reiss AJ, Roth JA, eds. Violence in families: understanding and preventing violence. Panel on the understanding and control of violent behavior. Vol. 1. Washington, DC:National Academy Press, 1993:221–54.

53. Paolucci EO, Genuis ML, Violato C. A meta-analysis of the published research on the effects of child sexual abuse. J Psychol 2001;135:17–36.

54. Brown J, Cohen P, Johnson JG, Smailes EM. Childhood abuse and neglect: specificity of effects on adolescent and young adult depression and suicidality. J Am Acad of Child Adolesc Psychiatry 1999;38:1490–6.

55. Nation M, Crusto C, Wandersman A, et al. What works in prevention: Principles of effective prevention programs. Am Psychol 2003;58:449–56.

56. Mrazek PJ, Haggerty RJ, eds. Reducing risks for mental disorders: Frontiers for preventive intervention research. Washington, DC: National Academy Press, 1994.

57. Pan A, Daley S, Rivera LM, Williams K, Lingle D, Reznik V. Understanding the role of culture in domestic violence: the Ahimsa Project for Safe Families. J Immigr Health 2006;8:35–43.

58. Alkon A, Tschann JM, Ruane S, Wolf M, Hittner A. A violence-prevention and evaluation project with ethnically diverse populations. Am J Prev Med 2001;20(Suppl 1):48–55.

59. Sue DW, Sue D. Counseling the culturally diverse: Theory and practice. New York: John Wiley, 2003.

60. Wickizer TM, Franklin GM, Mootz, RD, et al. A communitywide intervention to improve outcomes and reduce disability among injured workers in Washington state. Milbank Q 2004;82:547–67.

61. Mark GY. Oakland Chinatown's first youth gang: the Suey Sing Boys. Free Inq Creat Sociol 1997;25:41–50.

62. Rizzo M. Why do children join gangs? J Gang Res 2003;11:65–75.

63. Stone SS. Risk factors associated with gang joining among youth. J Gang Res 1999;6:1–18.

64. Kennedy D. Pulling levers: Getting deterrence right. National Institute of Justice Journal 1998;236:2–8.

65. Meyer AL, Cohen R, Edmonds T, Masho S. Developing a comprehensive approach to youth violence prevention in a small city. Am J Prev Med 2008;34(3S):S13–S20.

66. Griffith DM, Allen JO, Zimmerman MA, et al. Organizational empowerment in community mobilization to address youth violence. Am J Prev Med 2008;4(3S):S89–S99.

67. Hernández-Cordero L, Fullilove MT. Constructing peace: helping youth cope in the aftermath of 9/11. Am J Prev Med 2008;34(3S):S31–S35.

68. Payne PR, Williams KR. Building social capital through neighborhood mobilization: challenges and lessons learned. Am J Prev Med 2008;34(3S):S42–S47.

69. Mirabal B, López-Sánchez G, Franco-Ortiz M, Méndez M. Developing partnerships to advance youth violence prevention in Puerto Rico: the role of an Academic Center of Excellence. Am J Prev Med 2008;34(3S):S56–S61.

70. Akeo NP, Bunyan ES, Burgess KN, et al. Hui Malama o ke Kai: mobilizing to prevent youth violence and substance use with passion, common goals, and culture. Am J Prev Med 2008;34(3S):S67–S71.

71. Watson-Thompson J, Fawcett SB, Schultz JA. A framework for community mobilization to promote healthy youth development. Am J Prev Med 2008;34(3S):S72–S81.

72. O'Neill K, Williams KJ, Reznik V. Engaging Latino residents to build a healthier community in mid-city San Diego. Am J Prev Med 2008;34(3S):S36–S41.