A DIALOGUE

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Commentaries from Grantmakers on Fawcett et al.'s Proposed Memorandum of Collaboration

In the following series of commentaries, grantmakers respond to a proposal by Fawcett and his colleagues at the University of Kansas for a "model memorandum of collaboration."[1] Taken together, these commentaries offer a set of differing and complementary perspectives on the shared work of making communities healthier.

In the lead commentary, Marshall Kreuter of the US Centers for Disease Control and Prevention (CDC) helps us see the value of a new covenant among those working within and outside communities while cautioning that "the devil is in the details." Barbara Sabol of the W.K. Kellogg Foundation calls for the vision to keep our efforts focused on the prize: just communities without disparities in health status. Andrew O'Donovan of the Kansas Department of Social and Rehabilitative Services outlines a concrete plan and associated support system for a statewide effort to build healthier communities. In reflecting on the experience of their place-based work, Lisa Klein of the Ewing Marion Kauffman Foundation uses two contrasting case examples to highlight the importance of adjusting for context in community-based initiatives. Lawrence Green of the CDC, formerly with the Henry J. Kaiser Family Foundation, offers a historical context for this work, sharing his doubts about whether grantmakers' investments in community coalitions can bring about improvements in the health of communities. Marni Vliet, Tami Bradley, and Mary K. Campuzano of the Kansas Health Foundation describe the Foundation's evolving strategies for community-based grantmaking, highlighting the importance of communication with the people served. Finally, Al Tarlov, formerly with the Henry J. Kaiser Family Foundation, helps orient us to the common work of sociocultural change for population health, challenging the grantmaking community to review and renew its role as an instrument for societal improvement.

GETTING TO THE DEVILISH DETAILS

Marshall W. Kreuter, PhD

Fawcett and his colleagues offer us a "research-based proposal" outlining the key elements for effective collaboration.[1] The proposal is framed around seven factors that, according to the authors' 10 years of experience in studying community health partnerships in a variety of settings, appear to influence the process of community change and improvement. Researchers and practitioners will find that the seven factors are consistent with observations reported elsewhere in the literature.[2-7]

The proposal is presented in the form of an idealized social contract, or covenant, designed to prompt dialogue among three categories of partners: community partners,

support organizations, and grantmakers. The implicit assumption is that if these parties adhere to the spirit of the guidelines, many of the forces that conspire against successful community change would be eliminated or effectively managed.

From a practical standpoint, the central message that Fawcett et al. are trying to communicate lies not in the merits of the seven factors but in the context in which they are presented. Contractual language is employed to illustrate how the three general categories of partners would differentially undertake a collaborative community enterprise guided by the principles inherent in the seven factors. In so doing, they highlight (*a*) the synergy created by the purposeful and planned engagement of organizations in sectors both within and outside the community, and (*b*) the need for greater clarity and specificity about the role of the grantmaker or funding organization.

Others have emphasized the need for thoughtful engagement of outsiders in the process of community collaboration. In outlining the elements of successful community-rebuilding initiatives, Schorr points out that deficiencies in communities often originate outside the boundaries of those communities.[3] She suggests that this is why, in central city areas, "neighborhoods cannot turn themselves around without being able to draw on outside funding, experience, expertise and influence from outside the neighborhood." Schorr suggests that while outside support is inevitably needed to resolve severe community problems, the track record of both government and philanthropic funders has been imperfect, as characterized by this sentiments such as: "If you don't want us to tell you what to do, OK, we're out of here."[3] Collaborative partners must overcome such sentiments is if they are to develop the trust and the mutually supportive relationships that are essential to the success of their endeavors.[8–13]

Few would debate the common sense underlying Lasker's observation that people and organizations form partnerships because they believe that collaboration can help them attain things that they could not attain by themselves,[14] but anyone who has tried to apply this practical notion to community-level health promotion will be quick to point out that the devil is in the details, especially when those details are ignored. In matters of community collaboration and development, problems inevitably surface when planners fail to heed such details as a community's history and norms, or the perceptions community members hold about the motives and intent of outsiders.

Fawcett and his co-workers use contractual language as a means to add specificity to, and prompt dialogue about, the roles and responsibilities that different kinds of organizations will play in a community collaborative. It seems unlikely that we shall see, literally, the emergence of formal inter-organizational contracts, but as a *contractual* metaphor, the process may serve as a very practical tool to nudge participant organizations, including grantmakers, toward more informed and negotiated relationships, grounded in the common purpose of community improvement.

Readers should not conclude, either from the Fawcett et al. proposal[1] or Schorr's alert,[3] that the support being called for is nowhere to be found. The strategy employed by the Kansas Health Foundation (see Vliet et al. below) offers one example. The Henry J. Kaiser Family Foundation's application of the social reconnaissance method in selected Southern states,[5] the California Wellness Foundation's Health Improvement Initiative,[15] and the W.K. Kellogg Foundation's Community Based Public Health Initiative[16] provide clear examples of how grantmakers have specified their roles and made conscious efforts to nurture trust and provide support to communities. The Center for the Advancement of Community Based Public Health (CBPH), a direct outgrowth of the Kellogg initiative, is a national nonprofit organization that fosters community-based partnerships. The emergence of CBPH provides evidence that nurturing community support is by no means static. Among the guiding principles of the CBPH:

> [E]ach partner—whether a local neighborhood, health agency, or university—brings distinct but complementary histories, strengths, and perspectives to bear. As such, each partner and its representatives are acknowledged as having contributions of equal value for healing the community. Strategically combining these resources creates a power far beyond the capability of players working alone.[17]

Hidden in the phrase "strategically combining these resources" are the devilish details. Appropriately tailored to the needs and nuances of a given community, the "memorandum of collaboration" proposed by Fawcett and his colleagues constitutes a practical and useful tool to help community planners identify and untangle those details.

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WORKING TOGETHER FOR A JUST (AND THEREFORE HEALTHY) COMMUNITY

Barbara J. Sabol, MA RN

The W.K. Kellogg Foundation values the invitation for dialogue in the proposal by Fawcett et al.[1] Our contribution to the dialogue is to comment on an additional fundamental question that arises when this thoughtful proposal is considered in light of current research on social determinants of health: "Do the concept and practice in Healthy Cities/Communities work address those social injustices that research is finding underlie both ill health *throughout* a society and disparities in health status that have disproportionate adverse effects on disadvantaged groups *within* a society?" Would failure to address social injustices impede, limit, or bar continued progress and success in Healthy Cities/Communities work? The findings and commentaries of the researchers strongly suggest that the answer is yes. In what way and to what extent, then, does the proposal take into account social injustices as determinants of health? Is there room for improvement in how the proposal recognizes such determinants?

It will be helpful to view this fundamental question in terms of the idea of evolution, or stages of development, in Healthy Cities/Communities work. The proposal illustrates several current efforts to advance concepts, practice, and support (including training, technical assistance, and funding) to the next stage of development. The proposal aims to articulate and apply lessons learned from the field in order to move the work forward through greater intentionality.

We are very familiar with this experience in Kellogg Foundation health programming. We learned difficult but immensely valuable lessons from the field and applied them in a process of reformulating our programming and disciplining our thinking and practice. In 1986, we began a course of programming in which we funded, over time, more than 100 community-based, *problem-focused* models. I have added emphasis to "problem-focused" because the problem-focused approaches were not unlike the first "success" factor proposed by Fawcett et al.,[1] namely, "targeted mission" or targeting specific, concrete, measurable, defined objectives. What we found was that a significant number of problem-focused models evolved, as part of their natural course of development, to more comprehensive approaches. We also saw that greater comprehensiveness enhanced their effectiveness and their chances for long-term success and sustainability. We came to regard greater comprehensiveness as the next stage of development and reformulated our programming goal and strategies accordingly. Thus, our concepts and practice evolved based on learning from the experience of our grantees in the field.

Our experience suggests that the tight targeting recommended in the proposal, while highly useful for certain purposes, could become a limiting factor unless it is constantly and closely accompanied by another "success" factor that we recommend be added to the list of seven in the proposal. The recommended eighth success factor is creation, maintenance, renewal of—and adherence to—vision. Making tight targeting inseparable from adherence to vision would create pathways to greater comprehensiveness, enhanced sustainability, deepened and meaningful impact, and more opportunities to let Healthy Cities/Communities work evolve from a focus on discrete projects and single-measure outcomes to a focus on systems change.

The proposal makes several references to important arenas for systems change and social transformation. These references can return us to the fundamental question with which my commentary opened: whether Healthy Cities/Communities concepts and practice address those social injustices that operate as social determinants of health. I return to this key point in order to stress that a vision that is very strong and very clear about the causes of community ill health will be necessary to drive work that continues to evolve in its capacity to produce more and more significant outcomes that result in a genuinely healthy community. These social determinants of health include discrimination, income inequality, lower social and workplace rank, and public policies resulting in depletion of resources in central cities. Thus, it is not just vision per se, the research would suggest, that must be created and adhered to in order to evolve beyond the project or problem focus. It is a vision that incorporates—and confronts—social injustice and the creation of a just society. To capture this idea, the eighth success factor might be recast as "Creation, maintenance, and renewal of, and adherence to, a vision of a just and therefore healthy community."

Tightly targeted work on selected projects or problems is important and necessary, but it is not sufficient for the creation of healthy communities. Tightly targeted work must be inseparable from work toward realization of a vision. Indicators, incentives, and so on should follow

the same pattern. Leaders in the Healthy Cities/Communities movement need to speak in a way that allows participants in the movement never to lose sight of the vision and to understand how the steps being taken today link to the vision for tomorrow.

Broad guidance for the evolution of Healthy Cities/Communities work should help all of us, as participants, not get "stuck" in our own success. While we are celebrating our successes, we should be pushing ourselves along the path to the vision. A comparison might be made to the civil rights movement. Sitting at lunch counters was essential, hard, and dangerous. But if activists had stayed sitting at lunch counters for 20 years, what would the movement have achieved? They sat at the lunch counters and they kept the vision. They did both.

Movements—and organizational administrators and individual participants in the work of movements—want and need small victories on which the sun shines. Broad guidance for the evolution of the Healthy Cities/Communities movement must find ways to keep the pressure on, recognizing the adage "No struggle, no progress." It should encourage participants to celebrate—definitely celebrate—but then push ahead to collaborate on the next step.

The more steps toward the vision participants have taken, the harder that next step may become. The reason is that these steps toward achieving a vision of a just, and therefore healthy, community must necessarily bring participants closer to a metaphorical wall—the barriers we, as a society, have codified that block achievement of social justice. The vision must be strong and clear in order to sustain people when they hit that wall so that they can learn together how to bring it down.

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CONNECT KANSAS: A COLLABORATIVE VISION

Andrew O'Donovan, MA
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Carl Becker, in his essay "Kansas,"[18] reminds us that idealism must always prevail on the frontier. The frontier holds little hope for those who see things as they are. To venture into the wilderness, he said, one must see it not as it is but as it will be. Creating community environments where children are safe, connected to others, and supported by a web of concerned, involved, and responsible adults is the focus of the Kansas vision. While government cannot and should not be the solution to every problem, those in public service do have a special responsibility to build collaborative partnerships that better serve families and communities, develop thoughtful public policy, and invest resources in ways that achieve meaningful results.

The Kansas Department of Social and Rehabilitation Services, a state agency, has invested in a collaborative framework to support people and organizations concerned about the healthy development of children—community by community and neighborhood by neighborhood. The Connect Kansas: Supporting Communities That Care framework links more than 30 years of research and practical application, from knowledge about what puts children at risk and what protects them to knowledge about community and systems change that is guided by the seven facilitating factors identified through research by the University of Kansas Work Group on Health Promotion and Community Development and others.

Connect Kansas has four major components:

- A database of risk and protective profiles for all 105 Kansas counties organized according to nine desirable developmental outcomes for children and adolescents: (1) Families, youth, and citizens are part of their community's planning, decision-making, and evaluation. (2) Families and individuals live in safe and supportive communities. (3) Pregnant women and newborns thrive. (4) Infants and children thrive. (5) Children live in stable and supported families. (6) Children are ready for school. (7) Children succeed in school. (8) Young people choose healthy behaviors. (9) Young people make a successful transition to adulthood. The data, from several state partners, help communities focus on targeted missions and address issues that matter to them.

- A support system for community partnerships and coalitions around core competencies: community assessment, strategic planning, community action and advocacy, community evaluation, and leveraging resources. The 13 Regional Prevention Centers, Youth Friends of Kansas, and the Kansas Family Partnership provide a statewide network for local support.

- An Internet-based community documentation system that provides ongoing communication for local partnerships about changes they are making through their strategic action plan and allows state funders to identify progress toward the nine developmental outcomes. This system is managed by the University of Kansas Work Group on Health Promotion and Community Development in cooperation with the Southeast Kansas Education Service Center.

- Development and dissemination of best practices, supported through innovative publicly and privately funded partnerships such as the Six-State Consortium, the Seven-State Diffusion Study, the Four-State Integrated Prevention Study, and the State Incentive Cooperative Agreement.

Connect Kansas has been built on a strong foundation of research, practical application, and collaboration. It moves decision-making from state meeting rooms to the community, and it demonstrates the commitment that Kansas partners have in addressing the new frontier for the 21st century: building community support systems for the healthy development of children and adolescents.

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THE IMPORTANCE OF CONTEXT IN WORKING TOGETHER FOR HEALTHIER COMMUNITIES

Lisa Klein, PhD

Expanded definitions of both health and community include an emphasis on human/social components, with one result being an increase in the number of foundations that view Healthy Communities as fitting into their missions and funding portfolios.

The Ewing Marion Kauffman Foundation has identified building healthy communities as a critical part of its mission. This commentary is based on experiences with two communities in particular. In both cases, the Foundation provided grants targeting program operations and evaluation. Together with both grantees, the Foundation and the community collaborated, in large part, according to the model outlined by the Work Group at the University of Kansas.[1] The results were different for each community.

In one, community partners agreed on their vision and mission, defined objectives, and identified organizations that could help them achieve their goals in less than the recommended four months. They were able to create an action plan to bring about the desired changes and implement some interventions before the end of the first year. Formal and informal leadership within the community was enhanced, with the support of technical assistance by local support organizations and additional resources for leadership development provided by the foundation. An evaluation was conducted using the Work Group model for documenting community change. The results revealed progress or the lack thereof, and the community used feedback to target those areas not yet showing the desired changes. One suggestion that was acted on was to find ways to leverage other resources in order to sustain the positive changes. Following the "making outcomes matter" part of the model, the Foundation incorporated reporting on community outcomes into the grant and helped the community use the evaluation to seek more funding in order to sustain their ongoing programming.

In the other community, the project partners experienced great challenges from the beginning. Agreeing on their mission and goals proved difficult, as did attempts at developing an action plan. By the end of the first year, they had made little progress. High rates of transiency and a large degree of instability in the community made it difficult for true collaboration to develop among residents and with the Foundation. Despite the commitment by some community members and technical assistance from support organizations and the Foundation, any leadership that evolved was soon offset by movement out of the community. Few of the local organizations were able to provide the types of assistance needed. An evaluation after the second year predictably revealed that few community changes had been made and, of those, most had quickly leveled off.

Lessons from these two experiences have some implications for the proposed memorandum of collaboration.

First, the time suggested for developing the vision, objectives, and action plan should not be underesti-

mated. Some funders might consider a year a long time for planning, but in fact it probably takes most communities longer than that to collaborate fully and work toward achieving their goals. This seems to be particularly true when local support organizations are not available or do not have the capacity to provide the needed assistance. The community in my first example was more of what is referred to as a "ready" community, well positioned to identify and work toward making changes. The second is probably more typical of urban, at-risk communities and may be expected to move at a slower pace and require additional up-front assistance.

Second, grantmakers interested in not only helping to build healthy communities but in seeing those results sustained should be prepared to provide the multi-year funding commitments suggested in the model. Grantmakers are accustomed to funding in one-, two-, or three-year cycles. These examples underscore the degree to which longer-term resources (financial, human, and technical) are needed to do this work. The model also suggests that grantmakers help communities seek other funding; we found that leveraging additional support was critical.

Third, grantmakers should heed the advice in the model to link resources and outcomes. Foundations are responsible for making wise investments. Communities are responsible for working toward achieving their goals. Based on the above experiences, the Foundation learned valuable lessons about how to communicate the relationship between outcomes and funding. Linking resources and outcomes was successful after both parties understood that funding decisions would be contingent on evidence of work toward achieving outcomes, but that this would translate to funding only if outcomes were achieved.

Finally, the proposed model outlines several ways in which grantmakers can extend their role beyond traditional "grant and go" to include other types of assistance. In the second community described above, the Foundation convened more meetings with multiple stakeholders and offered more technical assistance in the form of training, consultation, evaluation, and communications than needed with other grants.

It will be interesting to see how far grantmakers are able to go beyond providing traditional one- to three-year dollar awards. The proposed model[1] outlines an integrated and comprehensive approach that involves communities, support organizations, and grantmakers. Perhaps the greatest challenges will be for all parties to see how much they can broaden their roles and change some of their own traditional practices.

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WORKING TOGETHER OR HANGING TOGETHER TO AVOID WORKING?

Lawrence W. Green, DRPH

Stephen Fawcett and his colleagues at the University of Kansas have reopened and concretized a dialogue that has occurred on many levels over many generations of foundation, federal, and state efforts to stimulate and support community initiatives in the areas of health and other forms of community development.[1]

The Kansas proposal, solidly grounded in the Kansas team's excellent research, reflects the assumptions of most practitioners who are trying to organize or mobilize community partnerships for health. Whether those assumptions will stand the test of time is for another debate on the thin reeds of evidence supporting coalition-based planning. Some grantmakers have lost faith in local coalitions as agents of change in the larger systems of state and national policies, economics, and practices that influence some aspects of local health.[19]

Their disappointment with the evaluation of coalitions they funded to control local health care costs notwithstanding, officials of the Robert Wood Johnson Foundation pressed ahead with Fighting Back: Community Initiatives to Reduce the Demand for Illegal Drugs and Alcohol. They vowed to incorporate five lessons in their funding of coalitions:

- Target relatively smaller communities.
- Address a highly visible issue that has a crisis perception around which participants can rally.
- Choose clearly defined, measurable goals and objectives to which participants can collectively aspire.
- Cultivate a real power base rooted in the community leadership.

- Develop processes that encourage tolerance of friction among participants.[20]

Like the Kansas proposal, the listing by grantmakers of lessons or principles of what seems to have made some coalitions more successful than others cannot guarantee that the next coalition funded will adhere to these principles, will succeed if they do, or will fail if they do not. The hard question that those demanding coalitions must ask is: What are the opportunity costs of working together when they must sacrifice working apart to maintain a coalition? Coalitions sometimes turn out, in my experience, to be a formula for stalemate, neutralizing of community action, protection of the status quo, intimidation or co-optation of smaller agencies, and burnout of energy that might have been devoted more efficiently to action by individual organizations or strategic pairings of organizations.[21] Coalitions often seem a hanging together to create a sense of community where there is little community or to provide comfort and mutual support in the face of discouraging circumstances in the community. These motives for coalitions can become a substitute for action and change.

The dialogue that Fawcett et al. have invited[1] need not be an attempt merely to square the Kansas team's research base with the anecdotal experience of grantmakers. There has been a lot of research on, and evaluation of, grantmaking in this mode; some of it has made its way into the published literature, and most of it is available in annual reports and other public records of foundations and government agencies. The approach proposed bears a close resemblance to the social reconnaissance approach originally codified by Irwin T. Sanders before mid-century.[22] After the "maximum feasible participation" legislation of the 1960s, Harold Nix exhumed and elaborated on the reconnaissance method in the 1970s for the CDC[23] and the *Journal of the Community Development Society*.[24]

The latter-day incarnation of this method by the Kaiser Family Foundation from 1988 to 1991 structured its Community Health Promotion Grant Program in the South. A series of grants in the Southern states and in Kansas, in collaboration with the Wesley Foundation (now the Kansas Health Foundation)[25] integrated national and state-level foundation and government grantmaking with local priorities, initiative, and mobilization and with support and intermediary organizations to provide technical assistance.[5]

The social reconnaissance collaboration in Kansas occurred at about the time when Francisco, Paine, and Fawcett undertook their decade of "monitoring and evaluating community coalitions."[26] Meanwhile, the Kaiser Family Foundation undertook a sweeping evaluation of its social reconnaissance strategy in the Southern states.[27] The report from this evaluation provides empirical answers to many of the questions raised by the Kansas team's proposal; some of the answers are encouraging, some discouraging.

The social reconnaissance method of the Kaiser Family Foundation included partnerships with many other national and regional foundations in the United States. It was featured in an article in the Council on Foundations magazine[28] and in Lester Breslow's projection to the future in "The Future of Public Health: Prospects in the United States for the 1990s."[29] It also received the 1990 Foundation Award of the National Association of Prevention Professionals. The reconnaissance method of grantmaking thus had influence among funding agencies, both public and private.

The Kansas team's proposal also reflects the methods of the Planned Approach to Community Health (PATCH) method of grantmaking and technical assistance from the CDC through state health departments to local communities, operating since the mid-1980s.[30] By 1992–1993, when the Kansas team was undertaking its decade of monitoring of community coalitions, 239 local health agencies were using PATCH.[31]

The Kansas proposal fits the PATCH approach more than the social reconnaissance approach in its emphasis on training for local community members. Kansas also attempts to overcome PATCH's and the social reconnaissance model's often frustrating experience of the community's priorities not matching the mandated priorities of the funding agency. Unfortunately, federal agencies such as the CDC have little control over this problem once the congressional appropriations have been fixed in vertical funding envelopes. Foundations might be able to allow a wider range of local priorities to survive the funding screen, but even foundations must set parameters around their scope of funding.

A related addition to the PATCH model that the Kansas team has recommended in its proposal is an emphasis on the importance of grantmakers making a commitment to long-term funding if projects perform well. They outline an incentive schedule with "bonus grants" and "outcome dividends." This cannot happen in federal grant programs without overhauling the appropriation methods of Congress and the budgeting cycles of the Executive Branch. It could happen, theoretically, with foundations, but the cruel reality is that the boards of most foundations become restless with any program that stays the course for more than a few years. They interpret the mission of foundations to "innovate" as a responsibility

to do something new every few years. They often have a limited endowment from which to reallocate funds to new (innovative) programs, so old programs must go. They cannot have it both ways—innovate and commit to long-term funding for current programs. The Kaiser Family Foundation's Community Health Promotion Grants Program had a 10-year commitment in the early documents outlining the program.[32] It lasted only half that long.

Government grant programs might do well to retreat from coalitions to the firmer footing of evidence for more focused interventions in institutional settings (schools, workplaces), homes, and clinical settings, combined with the regulatory and social policy tools at their disposal for broader environmental supports. Foundations might be the best grantmaking partners for the broader community-based, Healthy Community types of programs because they have greater flexibility to apply most of the guidelines offered by the Kansas team for grantmaking partners. These are sensible, time-honored principles, associated with the more successful community partnerships, but they might not hold up under the most rigorous tests of evidence that government-sponsored programs are increasingly demanding.[15]

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COMMUNITY GRANTMAKING: A STRATEGIC APPROACH

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For the Kansas Health Foundation, the decision to fund community-based efforts is grounded in a desire to meet its broadly defined mission—"to improve the health of all Kansans." Since its beginning, the Foundation has been committed to defining health in broad terms, ones that respond to the needs of communities. This, coupled with a charter that limits funding to the geographic boundaries of the state, provides an opportunity for funding that builds on the philosophical values of prevention and public health.

Through the years, the Foundation has shaped its funding priorities by listening to the people it serves across the state, external advisors, and the grantee partners it relies on in communities and within systems. With this input, funding has followed a continuum that started with health promotion and disease prevention efforts, moved toward the core principles of public health, and most recently incorporated the concepts of social determinants of health. With each phase, the understanding of health has widened; it now includes issues such as education and economics.

At the same time, each shift has allowed for more targeted funding that gets closer to the root causes of health problems. It is this understanding that allows the Foundation to remain true to its original mission while being responsive to community needs and complementary to other funding organizations, public, private, corporate, or community.

A Strategic Approach to Funding: Roles and Responsibilities

Among grantmakers, roles and responsibilities are defined by each organization's governing body and staff. As a private philanthropy, the Kansas Health Foundation views its responsibility as improving humankind and making change possible. Because it is a mission-driven organization, program development begins with the mission as its centerpiece. Program areas are developed by staying attuned to the population served in terms of both needs and environmental influences and staying true to the philanthropic roles of educating, convening, serving as a catalyst, and developing leadership.

Today, the Foundation focuses its grantmaking in three defined areas: public health, leadership, and children's health. Funding is provided at the system level (universities, public health departments, and schools) and at the community level, usually by asking communities to bring together their many sectors to address specific health concerns. For several years these concerns centered on prevention and issues such as adolescent pregnancy, substance abuse, and cardiovascular disease. More recently, the Foundation has provided funding for consolidating health systems in rural communities, with a goal of focusing communities on the importance of health promotion and disease prevention. In the past two years, the Foundation has started exploring an approach that involves asking communities to focus their attention on building assets for their children and youth.

Each of these approaches has:

- Responded to expressed needs (for example, lowering the incidence of teen pregnancy, lowering morbidity and mortality rates, access to services in rural regions).
- Provided funding opportunities that established expected outcomes but, as a whole, allowed the community along with supporting partners, such as a university technical assistance team, to define its own plan of action.
- Focused on changing the environment in which people live, so that policies, cultural norms, and environmental influences change in order for health behavior to improve. Very few direct service programs were funded within communities.
- Focused on making strategic change possible at the system and community level.

For many foundations, the guiding principle for this kind of funding is that community health is best defined, owned, and improved by the community itself. One project director from rural Kansas defines it by saying: "If you've seen one rural community, you've seen one rural community"—in other words, a cookie-cutter approach to funding communities does not work and should be avoided.

Challenges and Opportunities

Through formal and informal evaluations of initiatives, the Foundation has identified a set of lessons learned as follows:

Leadership: The right leader can make or break a community-based initiative. Efforts need to be made to support traditional leaders, recruit new generations of leaders, and find ways to recruit nontraditional leaders. A related issue is identifying the appropriate outside technical assistance to develop community leadership.

Common ground: Foundations constantly endure a perception of pushing their own agendas rather than responding in a collective way to the needs of a group of people. Finding the common ground (sometimes referred to as a shared vision), rather than battling over differences, can fast-forward a project from the beginning. It breaks down barriers, including "turf protection."

Formative evaluation: Providing ongoing feedback about how efforts are improving, or where assistance is needed, can encourage and sustain change. Playing "gotcha!" when funding ends does not benefit the grantee or the funder. At the same time, a challenge for funders and evaluators working in communities continues to be establishing meaningful intermediate and distant measurements of change. Of course, related to this is measuring the actual impact of funding, with the many—and complex—influences on community health.

Long-term funding: Changing human behavior, particularly effecting the complex lifestyle changes that public health often demands, is difficult and usually takes more time than traditional funding streams allow. Larger grants may not be necessary, but funding beyond one, three, or five years needs to be considered to allow for sustained changes.

Communication strategies: Grantmakers need to incorporate communication strategies, including listening to the people they serve, in order to develop initiatives that are both responsive and effective in communities. For example, sometimes the appropriate activity may be a "wants" assessment rather than a "needs" assessment. In addition, targeted communication efforts can set the stage for awareness and attitude changes that lead to positive health.

Each of these lessons implies opportunities to do good work, but ultimately, grantmakers need to listen, learn, and respond in ways that help improve the lives of the people who call their community home.

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NEW ROLE FOR FOUNDATIONS?

Alvin R. Tarlov, MD

In the 1970s, while at the University of Chicago, I tried to improve the health of the people of the Woodlawn neighborhood using medical services. In the 1980s,

while at the Henry J. Kaiser Family Foundation, colleagues and I tried to improve the health of the population of several whole states and numerous communities across the United States using community organization and health education to achieve changes in health behaviors.

Both of the above efforts, although successful in some ways, did not achieve the population health improvement objectives hoped for. Both programs were adequately funded. The results of both programs fell short of the vision because of two conceptual shortcomings in the strategies used to improve population health.

First, concepts for improving health at the population level too often rely on a logic based on work with individuals. The association between the risk behaviors of individuals and more distant health outcomes for whole populations are not particularly strong. Yet, many intervention strategies, including those I have designed, rely on the mistaken idea that we understood an individual's risk for a given health outcome well enough to predict how a particular health care or behavioral intervention would affect a whole population. We cannot base approaches to population-level health improvement solely on what we learn from interventions with individuals.

Second, there are five known categories of determinants of population health: genes (biology), medical and public health services, health behaviors, societal characteristics, and the total ecology of all living things. Michael Marmot's analyses seem to show that whereas health behaviors were a predominant determinant earlier in the 20th century, societal features centering around social inequality have risen to become a major determinant in recent decades.[33] The determinants of population health probably comprise a complex system of interactions, feedback, and synergistic and cancellation effects. Significant and cost-effective population health improvement at the community (population) level requires that modifications be made in all five categories of determinants.

Fawcett et al.'s proposal[1] builds on their excellent work in community development for more than a decade. Specifying seven factors that are key ingredients for building community health drawn from their on-the-ground actual experiences, their emphasis on community and systems change, and the ambitiousness of their ideas are attractive and deserve serious attention.

I suggest an even broader perspective, with added emphasis on medical and public health services, societal characteristics (especially those that limit opportunity, position, privilege, self-efficacy, and self-fulfillment), and the ecology of all living things. Socio-structural remodeling (community and systems change in the authors' terms) requires consideration of ways to build community cohesion, trust, and social capital. The roles of local, state, and federal government as intimate participants in the collaborative partnership should be highlighted. This broader and more inclusive intervention strategy and an acknowledgement of the importance of some socio-structural modifications will avoid the tendency to focus a program's actions on individuals instead of a more appropriate focus on the population as a whole. I like the Fawcett et al. proposal and recommend its acceptance, but a broader view of interventions to improve population health will make it even more attractive.

Turning to the challenges to grantmakers (foundations, government agencies, business, private wealth), the proposal calls for a much more activist role for foundations directly in the community than most foundations have played. Examples include making financial and role commitments of a decade or more; acting as a broker to bring in more foundations, state agencies, and other grantmakers as funding partners to support the community effort; using a foundation's moral force to facilitate systems change and to secure access to sensitive data; using foundation funds to build infrastructure, such as information and communication technology; and providing funds for a financial bonus system to reward communities materially for exceptional accomplishment.

These are counter-conventional recommendations for the grantmaking community. Personally, I favor an expansion of foundations' activism, especially in dimensions that are beyond a community's reach. I suspect that while accommodating the limitations Congress and the Internal Revenue Service impose, the foundations have come to rely on the grant as their only instrument for social improvement.

I would like to see broad discussions within the grantmaking community around the provocative suggestions of the Fawcett team. Leadership for convening and moderating foundations' considerations could come from the Council on Foundations, the Independent Sector, Grantmakers in Health, and others. Participants should include foundation senior executives as well as board members. The process would benefit from Congressional and IRS input and from the participation of academic centers that have been established to study the role of foundations in American society. On reflection, it does seem to me that the time is right for foundations to examine afresh and more broadly the various tools that

could be fashioned to fulfill their promise to society in even more effective ways.

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