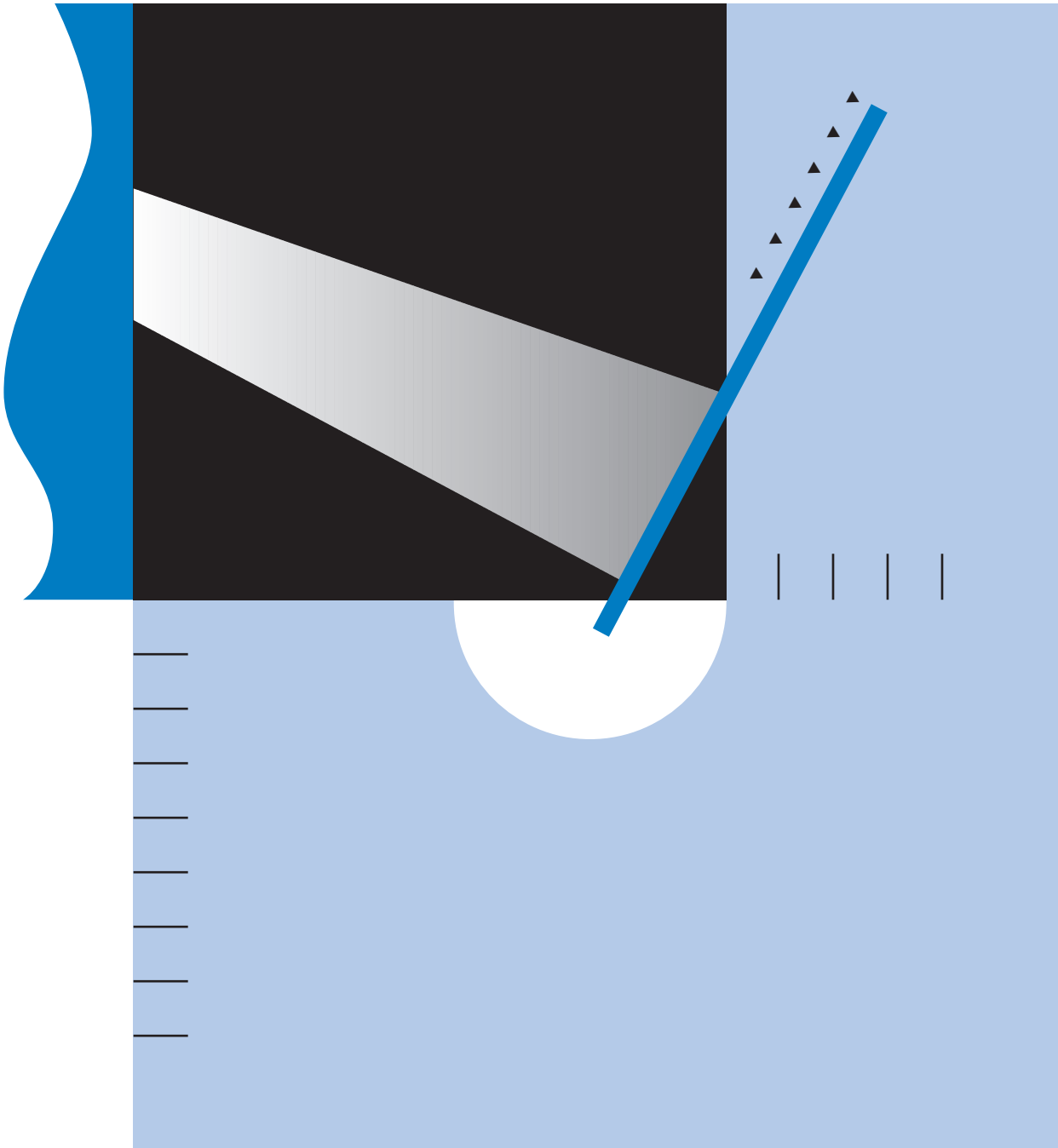
THE COLORADO TRUST

Promoting Health by Building Community Capacity

EVIDENCE AND IMPLICATIONS FOR GRANTMAKERS



Promoting Health by Building Community Capacity: Evidence and Implications for Grantmakers

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Foreword

Since its founding in 1985, The Colorado Trust has continually sought ways to increase the effectiveness of its grantmaking on the health status of Colorado residents. During the early years of its existence, the foundation pursued a fairly traditional approach to grantmaking, disbursing funds to those health-related organizations that presented the most worthy proposals in an open application process. Although this approach established The Trust as an important resource to the nonprofit sector in Colorado, the Board of Trustees questioned whether other strategies could stimulate more substantive, longer-term improvements in the health and quality of life of Coloradans.

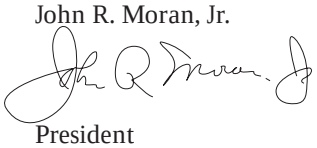
If a foundation is to make a real difference in the health status of a population, it must find and take advantage of untapped opportunities. What activities — including, but not limited to, giving away money — are within a foundation's scope of responsibility and are capable of making a difference? The Colorado Trust relies on a variety of complementary strategies which together are intended to increase both the supply and the utilization of effective health-promotion programs. For example, The Trust focuses significant attention and resources on efforts to develop, evaluate and publicize promising programs, particularly those that seek to improve birth outcomes and parenting. In addition, a number of Trust initiatives are designed to improve the ability of community-based organizations to select and implement programs that address critical health issues such as violence and teen pregnancy.

This report focuses on another important opportunity that has motivated grantmaking at The Colorado Trust — the building of "community capacity." The importance of community capacity is clear from the foundation's vision statement, which includes the precept that, "The Colorado Trust believes in the intrinsic capacity of communities to define and solve their own problems." Rather than simply providing financial support to a locally based program for some number of years, The Trust's initiatives seek to nurture the capacity of Coloradans to become even more effective in addressing whatever issues influence their community's health. Grantmaking components such as planning processes, technical assistance, grantee networks and a culture of learning are designed to help local residents and organizations build their skills, knowledge, leadership abilities, relationships and sense of efficacy.

Although The Trust's capacity-building initiatives have been recognized for their benefits in strengthening the "civic infrastructure" of communities, some individuals have questioned whether this approach is appropriate for a health foundation. This scrutiny has become more pronounced recently with the proliferation of "conversion foundations," which are established out of the sale of a nonprofit healthcare organization such as a hospital or health insurance system. This report reviews research that has begun to document the benefits that increased community capacity has on the health status of a community. On outcomes as "hard" as mortality, birth weight and violence, researchers have shown that higher levels of capacity (e.g., more civic engagement, more trusting relationships among neighbors, greater willingness to act for the common good) lead to higher levels of health.

Health and quality of life depend upon not only the absence of disease, but also a host of nonmedical factors, including social capital, environmental quality, economic well-being and cultural norms. Each of these areas offers a potential "investment opportunity" for foundations charged with promoting health. For The Colorado Trust, one of our most important investment strategies is the granting of resources that strengthen the fabric of communities and the problem-solving capabilities of their citizens.

John R. Moran, Jr.



President
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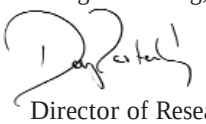

Director of Research and Evaluation
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Executive Summary

Over the past decade, a growing number of philanthropic foundations have been established out of the sale of nonprofit hospitals, health systems and health plans. These "conversion foundations" bring an infusion of new dollars to the cause of health promotion in the United States, although it is important to remember that this funding pales in comparison to spending on health within the public and private sectors. As the new conversion foundations develop their missions and grantmaking strategies, they face critical decisions about the role they will play in advancing health. For example, should the foundations act as a supplementary funding source (for example, by subsidizing medical care among the working poor in a community), or alternatively as an *investor* (by strategically targeting organizations or issues that have the potential to bring about more fundamental changes in how the community approaches health-related issues)? If the foundation chooses to act as an investor, what are the most effective leverage points for those investments? What resources, other than dollars, does the foundation have at its disposal to bring about the desired changes?

The concept of *community capacity* serves as one important target for foundation investment. In the context of The Colorado Trust's grantmaking philosophy, community capacity consists of a number of distinct elements that determine a community's ability to prevent disease and promote health: skills and knowledge, leadership, sense of efficacy, trusting relationships and a culture of learning. Community capacity overlaps with, but also extends the notion of "social capital." These sorts of capacity exist in an innate way within all communities, but are never fully realized.

Through deliberate and sensitive intervention, a foundation has the potential to "build" capacity in the sense of pushing the residents and organizations of a community toward their full potential. Among the strategies that might be used to promote community capacity are: (1) convening in a neutral forum the various individuals and organizations with a stake in an issue, (2) initiating community-based planning efforts, (3) helping organizations develop the capabilities of their board and staff, (4) training local leaders, and (5) bringing grantees together in networking meetings that allow for mutual learning.

A growing body of research indicates that an increase in community capacity produces tangible payoffs in health status. For example, states with greater levels of trusting relationships and civic participation tend to show lower levels of mortality, both in an overall sense (i.e., age-adjusted mortality rates) and for specific causes of death (e.g., infant mortality, heart disease and malignant neoplasms) (Kawachi et al., 1997). Another study found that violence rates vary across neighborhoods as a function of "collective efficacy," defined as the willingness of residents to intervene in instances of threat or criminal behavior (Sampson, Raudenbush and Earls, 1997). More and more evidence points to the importance of factors such as strong intracommunity relationships, leadership and efficacy as determinants of physical well-being.

The studies documenting the effect of community capacity on health build on a larger and more established research literature that investigates the linkage of environmental, cultural and economic factors to health. Namely, people are significantly healthier in those places where the air and water are cleaner, where cultural and religious norms support a healthy lifestyle (e.g., diet, smoking, drinking, physical activity and seat belts), and where there are adequate economic resources to support residents' basic needs and to create a sense of opportunity. Community capacity represents an *independent* predictor of health, explaining additional variation in health status as one looks across neighborhoods, cities, states or countries.

Taken together, the research on geographic differences in health status indicates important leverage points in the realm of health promotion. In other words, if a foundation is able to positively influence factors such as the quality of the environment, health-related norms, economic resources or community capacity, the available research suggests that improvements in health status will follow (although maybe not immediately). Obviously, achieving these societal-level shifts is no small task. Certainly no single organization can hope to simultaneously affect the physical environment, the local culture, the economic vitality

of the community and the different elements of community capacity identified here. Thus, improving the health of a community must involve a coordinated effort among the many public, private and nonprofit organizations that include health as a theme in their mission. Each organization brings its own unique perspective and competencies to the larger task of improving community health. Philanthropic foundations — because of their largely neutral political position, their significant financial resources and their ability to prod grantees through monetary incentives and coaching — are in a strong position to achieve substantive improvements in community capacity.

1. Introduction

What is the most effective strategy for promoting the health of a population? This is the defining question not only for medical institutions and public-health agencies, but also for a new generation of philanthropic foundations. Although the natural tendency is to provide medical goods and services, recent research suggests that other sorts of investment may bring about gains in health that are at least as large. In particular, building community capacity may be an especially cost-effective means for a health-oriented organization to achieve its mission.

1.1 The Emergence of Conversion Foundations

Over the past decade, nearly every state in the U.S. has seen at least one of its nonprofit health-related organizations (hospitals, medical centers, health plans) transformed into a for-profit corporation — through either a sale, merger, acquisition or joint venture. When such a conversion takes place, the proceeds are typically used to establish a new philanthropic foundation. These foundations vary tremendously in size. The sale of community-based hospitals tends to yield foundations with an asset base of between $50 million and $200 million, while the conversion of California's Blue Cross/Blue Shield system yielded two foundations (The California Endowment and The California Healthcare Foundation) with combined assets of more than $3 billion.

These new "conversion" foundations typically adopt a mission that calls for promoting the health of whatever geographic region — city, region or state — was served by the organization whose sale endowed the foundation. Indeed, in many states, the attorney general and/or state legislature have begun to play an active role in ensuring that the mission of conversion foundations is comparable to the mission of their predecessor institutions. Thus, most conversion foundations emphasize "health" in their grantmaking.[1]

Given their origins in the health-care sector, conversion foundations have a natural tendency to fund *medical* goods and services to the community (e.g., paying for the construction of health clinics and supporting programs that increase access to medical care among low-income populations). This style of grantmaking is apt to be comfortable and familiar to the board and staff of conversion foundations, especially when they have "come over" from the organization that was sold. Medically oriented grantmaking also has a good deal of "face validity," in that most observers would expect the grants to produce substantive improvements in health.

However, just because medically oriented grantmaking is *obvious* does not necessarily mean it is the most appropriate strategy for the foundation. By fully exploring what influences the community's health, board and staff may arrive at an alternative grantmaking approach that better achieves the foundation's mission.

1.2 Meeting a Health-Related Mission: The Colorado Trust's Approach to Grantmaking

The Colorado Trust is one of the oldest of the conversion foundations, established in 1985 out of the proceeds of the sale of Presbyterian/St. Lukes Medical Center in Denver, Colorado. During the first five years of its existence, The Trust adopted a fairly traditional perspective in promoting health — supporting Colorado-based nonprofit organizations that were providing health-related services (e.g., prenatal care, shelters for victims of domestic violence and fitness programs on Indian reservations). Although the funded programs generally provided beneficial services, the Board of The Trust became concerned that as a grantmaking strategy, simply providing operating support for existing programs failed to gain the most leverage for improving health from the foundation's dollars.

In 1992, The Trust moved to an "initiative-based" approach to grantmaking. Under this approach, the foundation formulates *program models* that guide the selection of grantees, the services that are provided under the initiative and the values and expectations that The Trust promotes in interacting with grantees. Thus, rather than being completely dependent on good ideas flowing up from nonprofit organizations through their grant applications, The Trust plays an active role in the program-design process. In particular, founda-

1. Some of these foundations focus on "health" in relatively narrow terms (i.e., the absence of disease), but many have adopted the World Health Organization's definition, which encompasses the mental, emotional, spiritual and social aspects of well-being. This report demonstrates that even if health is viewed narrowly in terms of morbidity and mortality, it still might be advisable for a foundation to focus its efforts on community-building activities because of the effect these activities have on physical health.

tion staff conduct research on current needs in the state, develop *general* program approaches and work with grantees to transform and tailor these approaches into effective activities at the local level. The overriding goal of this initiative approach is to produce health-related effects across the state that would not have occurred in the absence of the initiative.

The Trust's initiatives fall into four general categories:

1) Research and development efforts designed to yield new and effective models of health promotion. To date, The Trust has supported the development and evaluation of programs that provide: home visitation services to young, high-risk mothers; counseling and case management to women who have had an adverse birth outcome; and risk-appraisal information and counseling to women who are contemplating pregnancy;

2) The convening of representatives from different sectors and organizations for the purpose of generating new solutions to complex, health-related problems (e.g., the lack of primary-care providers in rural parts of the state, relatively low rates of immunization among children under two years of age and the affordability and accessibility of medical care);

3) Strengthening the ability of nonprofit organizations to select, plan, implement and refine effective programs (e.g., violence-prevention programs and home visitation programs); and

4) Building *community capacity*, defined as the set of strengths that residents individually and collectively bring to the cause of improving local quality of life.

This last strategy — building community capacity — may seem to be only tangentially related to the cause of health promotion. The Trust believes, however, that the social, economic and spiritual context within which we live either supports or detracts from our ability to cope with health threats. When we are nurtured by supportive social networks, a healthy economy, outlets for creative expression and forums that allow us to learn what works, we are much better equipped to face threats such as illness, violence, poor birth outcomes and abuse. Correspondingly, a foundation can promote health through initiatives that strengthen the relationships among individuals and organizations within the community; allow more effective problem-solving around health issues, and more generally, allow a community to recognize and make the most of the resources that exist within it.

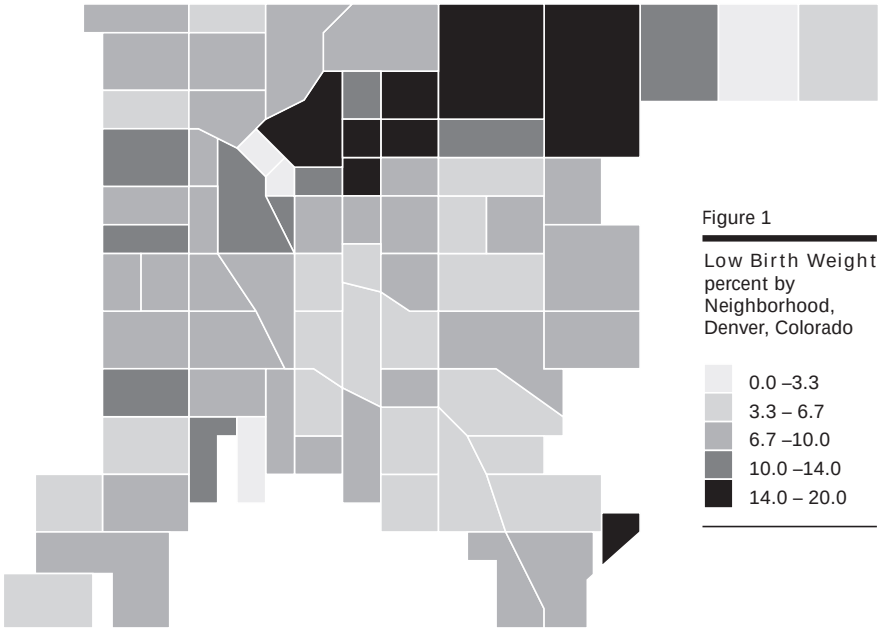
1.3 Overview of the Report

This report looks critically at the rationale for a capacity-building approach to promoting health. In particular, we review a body of research that suggests that strengthening a community's capacity or infrastructure will improve the health status of its residents. Such findings imply that community capacity is a leverage point for health promotion.

Recognizing that community capacity is positively related to health is only the first step in achieving healthier communities. There remains the crucial question, "How can a foundation or other health-oriented institution effectively build community capacity?" This report reviews some promising strategies for building community capacity and concludes by considering the longer-range prospects for this approach to grantmaking.

2. Factors Underlying Geographic Differences in Health Status

The hypothesis that building community capacity will lead to improvements in health is supported by a line of research that explores geographic differences in health status. It has been long recognized that levels of health vary dramatically from one place to another — between neighborhoods, cities, counties, states and countries. Statistical analyses can be used to identify the factors that account for this variation, that is, to explain why a particular place has either a high or low level of health. In a very real sense, the explanatory factors that emerge from these analyses point to the underlying determinants of health.



In this section, we provide a bit more detail on methodologies that are used to explain geographic variation in health. A review of the research literature shows that environmental, cultural and economic factors each play an important role in determining a population's health and thus provide opportune avenues for intervention. In Section 3 of the paper, we will move beyond these "traditional" leverage points to consider the role of community capacity.

2.1 Using Statistical Analysis to Locate the Determinants of Health

A growing body of research has shown that one's health is strongly related to where one lives. In 1995, the infant mortality rate in Massachusetts was 5.2 deaths per 1,000 births, while in Mississippi it was double that — 10.5 deaths per 1,000 births (National Center for Health Statistics, 1997). Health status also varies markedly from county to county within the same state (Goldman, 1991). Within Colorado, the 1996 rate of death from lung cancer ranged from 9 deaths per 100,000 in Douglas County to 72 deaths per 100,000 in Mesa County (Colorado Department of Public Health and Environment, 1997). Similarly, levels of health differ dramatically across neighborhoods within the same city. Figure 1 shows how the rate of low-weight births varies throughout the City of Denver — from zero percent to 20 percent.

Why is it that some areas have a much higher number of deaths than others? What aspects of the local "community" account for these geographic differences? More particularly, why do some communities (whether defined as neighborhoods, towns or regions) afford their residents a seemingly higher level of health status? One approach to answering this question is to use statistical techniques such as multiple regression analysis to "explain" the variation in health status between places. In these studies, each place is measured both on the health-status measure and on a number of variables that are hypothesized to account for the between-place differences in health. For example, one might hypothesize that the differences we observe between states in colorectal cancer mortality are due, at least in part, to differences in diet. To test this hypothesis, one would examine whether the pattern of between-state differences in colorectal cancer corresponds to geographic patterns in diet, as measured by something such as the percentage of fat in the average resident's daily diet. To the extent that the pattern for the outcome measure is similar to the pattern for the predictor, a regression analysis will show that the predictor "accounts for a significant portion of the variation in the outcome."

This geographic approach to analysis is a common tool for gaining insights into the determinants of health. In particular, analyses of this sort have shown that health is strongly influenced by nonmedical factors. A study by Bird and Bauman (1995) demonstrated that the variation that occurs between states in infant mortality results to a great extent from

between-state differences in socioeconomic factors (e.g., poverty rate, educational attainment, racial composition and degree of segregation between races). Together, these "structural" variables accounted for 64.5 percent of the between-state variance in infant mortality. In contrast, the level of health services available in the state — measured through physician-to-resident ratios, level of prenatal care and state expenditures on health care — accounted for only 31.5 percent. In other words, the difference we see between states in infant mortality stems more from the economic health and educational infrastructure of the state than from the more specifically health-oriented resources.

This line of research indicates that health is influenced by a whole host of factors. In the remainder of Section 2, we review the literature that shows the linkage between health and three important classes of predictors: the quality of the environment, cultural norms and the health of the local economy. This review sets a context for thinking about health as a product of the conditions that define where we live (although individual behavior and genetics also play an important role). Then in Section 3, we move to the hypothesis that the level of "community capacity" present within our community is an important contextual factor in the determination of health.

2.2 Quality of the Environment as a Predictor of Health

Among all cancers, the link between lung cancers and environmental conditions has been most clearly established. While cigarette smoking continues to be the primary risk factor for lung cancer, environmental exposures have also been found to contribute differentially by region, by occupational categories and by selective exposure to known carcinogens.

- Clear occupational risks for lung cancer have been established for workers exposed to crocidolite (an amphibole asbestos fiber). Areas with the highest rates of mesothelioma are those where crocidolite is mined and in dockyard areas (because of the use of crocidolite as an insulation material in naval ships). Workers at risk include miners, shipyard and insulation workers and those employed in construction trades (Ross and McDonald, 1995).

- A close relationship has been found between exposure to nickel and the risk of high lung cancer, particularly among workers in nickel refineries (Shen, 1994).

- An elevated risk for lung cancer has also been found among foundry workers exposed to polynuclear aromatic compounds and silica in iron/steel foundries, as well as those exposed to chromium and nickel fumes in steel foundries (Tossavainen, 1990).

- More broadly, higher rates of lung cancer have been found in communities located near some types of industries, such as non-ferrous smelters. The research results suggest that exposure to air pollution needs to be considered along with other risk factors in understanding the incidence of lung cancer within particular areas (Pershagen, 1990).

- Relatively high levels of ambient and indoor pollutants pose a particular risk for cancer in areas of central and Eastern Europe, where the emissions from heavy industries continue to exceed World Health Organization guidelines because of the lack of emission-control technologies (Jedrychowski, Maugeri and Bianchi, 1997).

- Increases in asthma morbidity and mortality are associated with specific types of air pollutants, such as sulphur dioxide, ozone and particulate matter (in particular, diesel exhaust emissions). Air pollutants are thought to act as irritants and to increase airway hyperreactivity (D'Amato, Liccardi, and Cazzola, 1994).

Although the examples here all relate to lung disorders, many other health outcomes (e.g., heart disease, infant mortality, birth defects, breast cancer) have been shown to vary across places as a function of pollution levels (Goldman, 1991).

In addition to pollution, there is a very different set of "environmental" predictors of health. Namely, health has been shown to vary as a function of the "built environment" (e.g., population density and housing stock), particularly in urban areas::

- Living in a high-density community is predictive of risk behaviors such as substance abuse and risky sexual practices among youth (Dryfoos, 1990).

- Violence levels are greater in more densely populated areas with multiple-dwelling households (National Research Council, 1993).

- Interpersonal violence is also higher within areas that have a higher density of alcohol outlets (Schribner, MacKinnon, and Dwyer, 1995).

2.3 Cultural Predictors of Health

Beyond environmental factors, *cultural norms* also relate to geographic differences in disease patterns. In particular, differences have been found among communities in terms of the extent to which particular risk behaviors are normatively accepted or not.

- Comparisons of age-adjusted cancer rates between Mormons and non-Mormons in Utah show that for both male and female Mormons, cancer rates are 24 percent lower than the comparable United States rates and 50 to 60 percent lower for cancers related to smoking. These differences have been attributed to the behavioral norms established by the Mormon Church that prohibit smoking and alcohol consumption (Lyon, Gardner and Gress, 1994)

- A comparison of lung cancer mortality in Canada revealed that the two areas with highest rates of smoking prevalence for over 20 years (Quebec and the Atlantic provinces) have the highest rates of age-adjusted lung cancer deaths (Brancker, 1990).

- Variations in ischemic heart disease mortality compared across 17 countries suggest that four-fifths of the geographic variation can be explained by differences in serum cholesterol levels (Law and Wald, 1994), attributable in part to diet and other lifestyle patterns.

- Seat belt use has been found to vary among communities depending on resident characteristics such as the percent of elderly persons and the mix of blue/white collar workers. Consistent seat belt use has been found to be positively correlated with socioeconomic status indicators such as home value (Shinar, 1993).

- Racial differences in seat belt use have been found to be related to differences in a belief in destiny. Prevention campaigns are urged to consider culturally relevant and sensitive approaches to minority populations (Colon, 1992).

- The presence of mandatory seat belt laws (such as in Michigan) has been found to be associated not only with greater seat belt use, but also with a 19 percent reduction in hospital admissions for automobile occupant injuries and a 20 percent reduction in injuries to extremities (Wagenaar and Margolis, 1990).

2.4 Economic Predictors of Health

In exploring geographic variation in health, the concept of *economic resources* consistently emerges as an important predictor — health is lower when the community is poorer. A review conducted by the National Research Council (an affiliate of the National Academy of Sciences) found that poverty was linked with child abuse and neglect, as well as adolescent violence (National Research Council, 1993). A similar review by Dryfoos (1990) concluded that poverty is also predictive of substance abuse and risky sexual behavior among adolescents. Research has also linked teen childbearing to economic factors, including the mother's income level (Gazmarian, Adams and Pumice, 1996) and the economic health of her neighborhood, as indicated by high levels of poverty and unemployment (Dryfoos, 1990), a lower percent of workers with managerial and professional jobs (Brooks-Gunn et al., 1993) and a lower presence of high-status workers (Crane, 1991).

A pair of studies sponsored by The Colorado Trust shows that economic factors exert a strong effect on low birth weight and teen pregnancy within the city of Denver:

- Geographic differences in low birth weight were studied using a multilevel regression analysis method that allowed neighborhood and individual level variables to be considered simultaneously. Among all the variables considered, maternal smoking and male unemployment were found to be the strongest predictors of whether or not a child would be born with low birth weight. A 10 percent difference in male unemployment between neighborhoods translated into a 61.5 gram (2.2 ounce) difference in birth weight for a preterm birth, after controlling for individual factors. The results suggest that both individual- and neighborhood-level strategies are appropriate for the prevention of low-birth-weight births. In addition, the identification of high-risk neighborhoods can help to target interventions toward individuals who are particularly at risk (Johnson et al., 1996).

- Higher rates of teen pregnancy were found in those neighborhoods with high rates of female unemployment, low salaries and high percentages of vacant housing. As might be expected, female unemployment was, in turn, found to be strongly correlated with other socioeconomic indicators, including poverty, male unemployment and the proportion of female-headed households. The more general literature has already established a strong connection between teen pregnancy and poverty. The importance of female unemployment as a predictor of teen pregnancy suggests that in some neighborhoods, youth have few positive female role models and a limited sense of what their future prospects might be (Drisko et al., 1996).

While the relationship between economic status and health status has long been recognized within the public health field (see, for example, Syme and Berkman [1981] and Blane [1995] for reviews of the literature), the newer studies described earlier provide a crucial addition to our understanding of how economic well-being influences health. Namely, we now know that the relationship between economic resources and health exists not only at the *individual* level, but also the *community* level; the community's level of economic resources exerts an *independent* effect on the health of its residents over and above the effect of personal wealth on personal health. The individual-level relationship means that an unemployed mother on welfare runs a higher risk of morbidity and mortality than does her gainfully employed neighbor. The community-level relationship means that the unemployed mother has better health if she lives within a "richer" community context; even if her own personal economic well-being remains constant, moving from a poor neighborhood to a wealthier neighborhood increases her probability of enjoying good physical health.[2]

The notion that lower economic status leads to lower health status is vividly demonstrated within the inner-city areas of some of the United States' major metropolitan areas. With the deindustrialization of these cities' economies over the past 50 years, there have been fewer employment opportunities (especially well-paying ones) for workers without extensive skills and education. The neighborhoods in which these now-unemployed individuals lived have lost much of their economic base. Moreover, middle-class residents have moved out of these neighborhoods to the suburbs, further eroding the number of jobs available (because the demand for goods and services has diminished). Without a viable local economy, poverty has become the norm within certain inner-city neighborhoods. Correspondingly, these neighborhoods have seen dramatic increases in violence, drug use, poor birth outcomes and a myriad of other health and social problems (Wilson, 1987).

The linkage between a community's economic resources and its health status reflects a number of underlying factors. For example, wealthier communities are able to support a richer mix of the resources that support health. These include medical services (hospitals, clinics, dentists, pharmacies), public-health services (effective systems of water and sewer sanitation, public-awareness campaigns), and resources outside the traditional definition of "health" (schools, grocery stores, recreation centers). Richer communities also have more wealth to redistribute from well-off residents to those who are struggling. In contrast, poorer neighborhoods are prone to income-driven crime, which increases the risk of violence to all of the community's residents, regardless of their own personal economic status.

So far, this discussion of economic predictors has focused on the *total* level of resources available within a community (measured either in aggregate terms or the wealth possessed by the average resident). The aggregate level of economic resources is a powerful predictor of community health,, but not the only one. Namely, the *distribution* of economic resources across the population also matters; health is lower when there is more disparity in wealth. For example, the National Research Council (1993) review found that areas with the greatest level of income inequality had higher levels of homicide (controlling for average income). This relationship also emerges when one compares states. States with greater disparity between the wealthiest half of the population and the poorest half of the population were found to have significantly higher age-adjusted mortality rates (Kennedy, Kawachi, and Prothrow-Stith, 1996) and poorer health on factors such as violence, low birth weight, smoking and sedentary behavior (Kaplan et al., 1996). Thus, health status depends not only on average wealth, but also on the disparity in income between the rich and poor residents of the state.

2. On the other hand, the research reported in Section 3 suggests that economic wealth is not the only important determinant. If a poor person moves to a neighborhood that is wealthier in *economic* resources, but poorer in the sense of *connectedness* among residents, the net effect on that individual's health may actually be negative.

3. The Relationship Between Community Capacity and Health Status

The previous section documented a number of environmental, cultural and economic predictors of health. Together, the research indicates that the health of a population can be enhanced by either improving the environmental conditions within the community, changing those cultural norms that reinforce risky behaviors, or strengthening the local economy. In this section, we consider another pathway to health promotion — building community capacity. We first define what we mean by this concept and then present the findings from a set of studies that show that community capacity is empirically linked to health.

3.1 The Nature of Community Capacity

Earlier in this paper, community capacity was defined as "the set of assets or strengths that residents individually and collectively bring to the cause of improving local quality of life." There are three key aspects to this definition. First, we are talking about assets that can be converted into an increased quality of life for the entire community, as opposed to assets that allow one particular individual or one particular firm to enhance its own financial standing. Second, these assets are indigenous to the community, not imported by a benevolent outside agent such as a government welfare program. Third, although some of these assets reside within individual residents, synergistic effects occur when a number of residents come together and use their assets in concert. Thus, community capacity is the currency that residents bring to the table when they are inspired (or threatened) by an issue that speaks directly to their collective well-being.

As defined here, the concept of community capacity is relatively broad, and as a result, not concrete enough to allow any sort of reliable measurement. Different analysts have chosen to operationalize community capacity in different ways. The Aspen Institute (1996), for example, presents a framework of "commitment, resources, and skills" that are hypothesized to facilitate community problem-solving. For the purposes of this paper, community capacity is defined according to a set of features that The Colorado Trust has found important within its community-based initiatives. In particular, when The Trust has attempted to build community capacity, the initiative has focused on one or more of the following five dimensions:

1) Skills and knowledge that allow for more effective actions and programs,

2) Leadership that allows a community to draw together and take advantage of the various talents and skills that are present among its residents,

3) A sense of efficacy and confidence that encourages residents to step forward and take the sorts of actions that will enhance the community's well-being,

4) Trusting relationships among residents that promote collective problem-solving and reciprocal caregiving ("social capital"), and

5) A culture of learning that allows residents to feel comfortable exploring new ideas and learning from their experience.

These five dimensions of community capacity are described in more detail below.

3.1.1 Skills and knowledge

Each resident of a community is a reservoir of talents and wisdom. Through our experience as children, parents, friends, workers, organizers and teachers, we each develop a unique set of skills that are useful in promoting the well-being of our community. These skills extend well beyond what is included in the economic concept of "human capital," which focuses primarily on the knowledge gained from formal education and training. The skills we bring to the task of earning a living (e.g., typing, computer programming, accounting, operating heavy machinery or repairing watches) are complemented by other talents that prove valuable in making one's community a better place to live (e.g., mentoring young adults, supporting neighbors in a time of crisis, discovering new approaches to a community-wide dilemma and preserving the habitat of local flora and fauna). Because of the traditional emphasis on marketable skills, we often overlook the other gifts that promote the community's well-being. Kretzmann and McKnight (1993) stress this broader continuum of skills and knowledge, and, in fact, have developed a strategy for "mapping" the resources that residents can offer to the cause of community building.

Much of the knowledge and skills that we use to

promote community well-being develops naturally through the course of our work and personal lives. However, some of what would help the community must be learned outside the scope of everyday experience. For example, a rural community may be confronting a problem with child abuse that a new parenting program can effectively address. Unless someone in that community has knowledge of that program, an opportunity will be foregone. Likewise, if local residents lack skills related to public awareness, program development, research, strategic thinking and the like, there will be limits to the amount of progress that the community will be able to accomplish.

The Colorado Trust's programming strives to build these sorts of skills and knowledge, not by bringing "experts" into the community to do the work, but rather by creating venues where community residents can learn from educators, consultants and individuals from other communities who are already doing the work. This strategy *builds* capacity in the sense of nurturing latent talents, rather than importing expertise. Each community comes into an initiative with myriad skills, not all of which are fully developed or even recognized. The challenge to the foundation is to find ideas and tools that allow the community's innate capacity to be strengthened. Indeed, this is the same challenge the foundation faces in making *itself* more effective.

3.1.2 Leadership

One particular skill is so critical that it deserves its own dimension — leadership. Leaders perform a number of crucial tasks that enhance community well-being, including focusing the community's attention on critical issues, moving residents to action, helping the community find a common mission or vision and bringing forth the talents and contributions of other individuals.

These tasks call for a range of leadership skills and styles. In particular, some leaders adopt highly visible positions and pull others forward with them, while other leaders stand further back and put their energy into mentoring and nurturing roles. The first type of leader can serve to catalyze a dormant community, while the second type of leader helps to bring effective action out of organizations or collaboratives dedicated to a particular issue (Mattessich and Monsey, 1997; Chrislip and Larson, 1994). All communities possess leaders of both types, but many of these individuals either don't recognize their potential and thus fail to assume leadership positions or else they are not offered the sorts of opportunities that would allow them to realize their leadership potential. Capacity-building on this dimension includes training in leadership skills but in large part involves encouraging individuals to identify and act on the leadership skills they already possess.

3.1.3 A Sense of efficacy

Health promotion ultimately requires *action* — either at the individual level (e.g., adopting healthy behaviors), at the family level (e.g., creating a nurturing home environment) or at the community level (e.g., initiating a youth group in one's church or neighborhood). To some extent, leaders can foster action (through example or encouragement). However, a more important determinant is the community's sense of *efficacy* (Bandura, 1986), defined as the degree of belief that one's actions will produce their desired results. A low sense of efficacy inhibits action out of a sense of futility ("I can't have any impact, so why try?"). As efficacy increases, people are more willing to act because they expect more from their actions. If, however, efficacy reaches an unrealistic level ("Whatever I try will work"), the individual is destined for a fall. Unrealistically high levels of efficacy are self-correcting; we learn the hard way that we can't control everything we hope for. However, unrealistically low levels of efficacy create a self-fulfilling prophecy; we never try anything ambitious and thus never come to recognize what we could, in fact, accomplish.

Efficacy exists not only at the individual level ("self-efficacy"), but also at the community level ("collective efficacy") (Sampson, Raudenbush and Earls, 1997). In particular, some neighborhoods, towns and cities have a collective belief that local residents can together achieve important goals. This sort of "can do" attitude is what the National Civic League attempts to instill with its All-American City Award program. Without such a belief, many of the health-related accomplishments that are within the ability of the community never occur because the necessary actions are never attempted.

3.1.4 Social capital

Interaction among residents to realize collective goals is one of the most well-developed constructs under community capacity. In particular, a large body of research exists around the idea of "social capital," which is defined as the presence of trusting relationships throughout a community that cause people to feel connected to one another and that allow for collective action (Coleman, 1990; Putnam, 1993; Potapchuk, Crocker and Schechter, 1997). Some of these relationships occur within the context of organizations, such as fraternal organizations, political parties, sports leagues and churches. Others are formed through more informal channels, such as bridge clubs, neighbors who look out for each others' children, or friends who meet over coffee every Wednesday. In all these examples, the sorts of relationships that fall under the concept of social capital are defined by mutual trust, cooperation and reciprocity. In other words, people come to count on one another. As Robert Putnam (1993) puts it, "Social capital is the glue that holds a community together."

In addition to this notion of connectedness, social capital also encompasses the concept of "civic engagement." Thus, a community with a high degree of social capital is not only full of individuals who know and take care of one another, but it also has a collective consciousness — residents work toward the common good of the entire community. In many ways, then, social capital equates to the "sense of community" that John Gardner (1990) promotes — a set of shared values, frequent face-to-face interactions and a willingness to care for one another. Together, these conditions lead a community's members to feel a sense of belonging and some measure of security.

Most theorists on the topic of "social capital" confine their definition to issues around civic engagement, social trust and reciprocal relationships. However, Lappé and DuBois (1997) add two other aspects that move "social capital" more toward "community capacity." In particular, these authors argue that:

> *Beyond our associative networks and the trust they engender, social capital must come to mean our collective intelligence — our capacity as a people to create the society we want* (p.120, emphasis added); and
>
> *To be useful, social capital must incorporate the concept of agency, defined by Webster as the capacity for exerting power* (p. 122).

In other words, for Lappé and DuBois, the construct of social capital incorporates the skills and knowledge that allow for the formulation of effective action, along with the leadership and collective efficacy that cause such action to actually take place. While mutually supportive relationships allow residents to care for one another and to create a strong base for collective action, additional sorts of capacity must be present if the community is to plan and take *effective* collective action.[3]

3.1.5 Culture of openness and learning

The last dimension of community capacity under The Trust's capacity-building philosophy relates to openness in the learning process. If a community is to be effective in understanding and addressing its health issues, the culture must promote a full exploration of those issues. This means that residents with diverse (and divergent) points of view need to be intentionally included and listened to during planning and agenda-setting exercises — whether these exercises are formal or informal.

For authentic learning to occur, the culture must do much more than politely acknowledge intracommunity differences. Namely, residents must come to appreciate that a complete understanding requires the forging of multiple perspectives into a common, agreed-upon vision. This requires forums where residents are comfortable both in speaking out (i.e., teaching) and in listening (i.e., learning). Such a culture is very compatible with Scott Peck's (1987) notion of "real community," which is achieved only when a group comes to embrace both the uniqueness of each person's experience and the commonalities that define human existence. Within Peck's frame-

3. We are not advocating a definition of community capacity that vests the knowledge and skills solely within a professional class of service providers. McKnight (1995) argues that when communities, especially inner-city neighborhoods, are "given" resources in the form of professional services (e.g., health clinics, mental health services, social workers or case managers), the propensity of residents to engage in caretaking activities can be crowded out, leading to a culture of dependency and "carelessness." However, there is no reason that skill-building and knowledge-building need take place solely at the level of the professional. Residents are capable learners and have a strong intrinsic stake in learning and applying the skills and knowledge that will promote their community's well-being.

work, one strives for a way of interacting that emphasizes learning and growth, rather than advocacy and winning. This is also consistent with Carl Moore's definition of "community:"

> *Community exists when people who are interdependent struggle with the traditions that bind them and the interests that separate them so that they can realize a future that is an improvement on the present* (Moore, 1996, p. 30).

A culture of learning involves not only an openness between individuals, but also an openness to the lessons that flow out of experience. The consequences of our actions are rich sources of knowledge, if we take the time and energy to understand them. As Peter Senge (1990) pointed out in *The Fifth Discipline*, organizations thrive only when they have systems for observing and learning from their actions. Only some of what we try works the way we intend, and even if an action works today, it may later become ineffective as the world changes. For a person, an organization or a community to be effective in the long run, there must be a balance between careful up-front planning and ongoing learning and refinement. This openness allows for continual maturing and the development of new capacities.

3.2 Research Showing a Link Between Community Capacity and Health

According to our definition, community capacity is a rather complex mixture of skills, relationships, propensities for actions and openness to learning. Each one links *logically* to health outcomes. For example, the stronger the leadership in a community, the greater the number of residents who are involved in health-promoting activities. Likewise,

> *even the poorest urban neighborhood has a dense and rich configuration of human relationships that can provide support, motivation, and direct assistance to reduce risky health behavior and community problems and to improve health conditions* (Freudenberg, 1998, p. 18).

A growing body of research shows the linkage between community capacity and health status is not only a common-sense one, but also is *empirically* supported. This section reviews some of the more definitive of these studies.

3.2.1 Social capital explains state differences in mortality

A recent study by Kawachi et al. (1997) found that social capital accounts for a significant portion of the variance in various indicators of health status. The analysis looked at between-state differences in age-adjusted mortality, infant mortality, and mortality from heart disease, malignant neoplasms, cerebrovascular disease and unintentional injuries. Each state's social capital was assessed with four indicators that tap into civic engagement, trust and helpfulness:

1) The number of groups and associations (e.g., churches, labor unions, fraternal organizations, professional societies or school groups) to which the average resident belongs;

2) The percentage of residents who disagreed with the statement, "Most people would try to take advantage of you if they got the chance;"

3) The percentage of residents who disagreed with the statement, "You can't be too careful in dealing with people;" and

4) The percentage of residents who disagreed with the statement, "People look out mostly for themselves."

Each of the four indicators was a strong predictor of mortality. States where residents belong to more voluntary groups and associations (i.e., higher civic engagement) have lower overall mortality rates and lower rates of mortality from heart disease and malignant neoplasms. The indicators of social trust provided even stronger predictive power, accounting for 64 percent of the variance in overall mortality as well as showing significant relationships with four of the five cause-specific mortality rates. All these analyses controlled for poverty levels and income inequality, which means that the measures of social capital produce an effect on health over and above the effect that economic resources have on health.

3.2.2 Infant health depends on neighborhood resources

Recent research further shows that the prevalence of infants born at low birth weight and the rate post-neonatal infant death are also influenced by the social and economic neighborhood contexts in which mothers reside. While individual maternal characteristics and behaviors have been clearly linked to the likelihood of having an adverse birth outcome,[4] communi-

4. See *The Future of Children* (1995) for a complete review of this literature.

ty contextual factors are now being identified as also having a strong influence.

■ A study in Chicago (Roberts, 1997) established that the chances of a woman having a low-weight birth tend to be lower in environments where there are more cooperative social networks. Although an index of economic hardship (combining neighborhood unemployment with poverty rates) and higher housing costs were found to increase a woman's chance of having a low-birth-weight child, other factors appeared to have a "protective influence." In particular, living in a neighborhood with a higher proportion of African-American residents and/or more crowded housing conditions was associated with lower rates of low-weight births. The researchers explain the results by suggesting that in communities segregated by race and income, social support systems develop that contribute to maternal health, particularly where childbearing is the norm and larger numbers of people contribute to the care of children.

■ In a study of all U.S. cities, LaVeist (1992) found that measures of political empowerment within the African-American community have an influence on child health, as measured both by the neonatal mortality rate (i.e., death during the first 28 days of life) and by the postneonatal mortality rate (i.e., death occurring after 28 days but before the end of the first year of life). In particular, postneonatal mortality was found to be lower in neighborhoods with higher "relative black power," measured by African-American representation on the city council. LaVeist has theorized that African-American communities that are able to elect African-American officials are also those with a strong community infrastructure as indicated by churches, civic groups, social organizations, civil rights organizations and neighborhood block associations. This infrastructure is able to ensure that more services are available to African-Americans, improving their quality of life and ultimately the health of newborns.

3.2.3 The effect of collective efficacy on violence

The link between community capacity and health outcomes is further demonstrated by Sampson, Raudenbush and Earls (1997), who used the concept of *collective efficacy* to explain why neighborhoods in Chicago differ in their level of violence. In this study, collective efficacy was defined as "social cohesion among neighbors combined with their willingness to intervene on behalf of the common good." According to the authors, collective efficacy consists of two distinct concepts: *informal social control* and *social cohesion and trust.* To measure a neighborhood's *informal social control*, the researchers asked local residents about their willingness to intervene in threatening situations. Five scenarios were tested: 1) children were skipping school, 2) children were spray-painting graffitti, 3) children were showing disrespect to an adult, 4) a fight broke out in front of their house and 5) the fire station near their home threatened to close. *Social cohesion and trust* was measured by asking residents whether people in the neighborhood were willing to help their neighbors, whether residents "got along" and could be trusted and whether they shared the same values. For each neighborhood, a c*ollective efficacy* score was created by combining the scores for *informal social control* and *social cohesion and trust*.

Collective efficacy was found to be a strong predictor of neighborhood differences in the rate of violent crime. Even when factors such as poverty levels and residential stability were controlled for statistically, collective efficacy accounted for a significant portion of the between-neighborhood differences in homicide rate and crime victimization. In other words, the neighborhoods in which residents are more apt to take action and to trust one another have lower levels of violence, other things being equal.

Given the importance of collective efficacy as a determinant of neighborhood quality of life, this study also attempted to identify the factors that lead to higher levels of collective efficacy. The authors found that residents were more willing to intervene for the collective good in neighborhoods with lower rates of concentrated poverty, low residential mobility, low concentrations of foreign-born residents and high rates of home ownership. Thus, *stability* seems to be a critical factor in fostering collective efficacy. In addition, the researchers caution against ignoring the fact that low levels of economic resources may limit the ability of communities to mobilize against crime.

3.2.4 Other supportive research

The research linking social capital and health builds on a much larger body of research that documents the strong effect of relationships on health status. For example, youth are at greater risk of violence, substance abuse and teen childbearing when they grow up in environments that harbor destructive relationships, a climate of futility, learned irresponsibility and a lack of purpose (Brendro, 1994). In contrast, factors that protect youth against risk behaviors include parent-family bonding and perceived school connectedness (Resnick et al., 1997; Battistich and Hom, 1997). In addition, bonding between adults and young people has been found to be essential for promoting youth resiliency and success:

> *Caring relationships that convey high expectations — including a deep belief in a youth's innate resilience — and provide opportunities for ongoing participation and contribution have been found in natural settings to be the key to successful development in any human system and for positive youth development* (Benard, 1996).

4. Strategies for Building Community Capacity

The empirical research reviewed in the last section indicates that at least some of the dimensions of community capacity, particularly social capital and collective efficacy, are strong predictors of health status. Assuming that these relationships will be borne out through further research,[5] the key question for a foundation is whether and how community capacity can be enhanced. A few foundations, such as the W.K. Kellogg Foundation and the Annie E. Casey Foundation, have long emphasized capacity-building at the community level (Chisman, 1996; Walsh, 1997). Many nonprofit leaders have encouraged the larger foundation community to invest in community capacity as part of their grantmaking (Gerzon, 1995; Sievers, 1995; Harwood Group, 1997).

While many observers agree that building community capacity is a laudable goal for foundations, there is less clarity on the question of precisely how to go about the capacity-building process. A great deal of thinking has gone into this question among academics and practitioners, but the preferred strategies are as varied as the backgrounds and ideologies of their proponents (see Wallis and Koziol [1996] for a review). For the purposes of this publication, we will simply present a sampling of some of these approaches, looking more particularly at some of the tools that The Colorado Trust has employed in its initiatives.

4.1 Paradigms for Building Community Capacity

Models of community-based intervention are based on different assumptions about the connection between the community and its social and health problems, what it is within a community that needs to change and the role of the community in bringing about change. As described in this section, some believe in building community capacity in a broad sense. Rather than focusing on specific community problems, these models focus on building the community's overall ability to respond to its problems, to be attentive to residents' self-defined needs and to promote economic capacity. Community develop-

5. Marshall Kreuter (1998) has embarked on a research program to determine exactly which elements of community capacity (and in particular, which aspects of social capital) are most crucial in influencing health.

ment projects of this sort are typically defined, managed and "owned" by the community.

Other models of change take a more targeted approach that addresses specific areas for reform. In these models, community capacity-building is directed toward specific prevention goals such as minimizing risk-taking behavior among youth. Community-based projects of this type rely on community participation and consultation rather than community direction. A more complete description of both approaches follows.

4.1.1 Empowerment approaches to community change

At the broadest level, community organizers such as John Kretzmann and John McKnight (1993) advocate that communities become empowered by using their existing assets as a path to community development. The talents of locally based groups of citizens become the basis for mobilizing broader community-building activities, including reconnecting local associations to a broader vision of community identity, redefining service systems and rebuilding the community economy. "Service-oriented" programs are downplayed because they teach community members that they are deficient and require expert assistance.

These community-building efforts are first and foremost defined by local residents to meet the needs of the community as perceived by community members. Using lessons learned from international development, Kretzmann and McKnight argue that community development must start from within, respecting local structures, supporting local visions and investing in local productive capabilities. Associated with this locally driven approach is the need for flexibility as each community defines for itself how to approach its own goals and priorities.

In this view, the development of community capacity is the basis for broader prevention benefits. Strengthening the capacity of community members to exchange information and mobilizing local citizens' associations develop local problem-solving skills. Empowered citizens then become the basis for broader community improvements, as suggested by Robert Putnam (1995):

> *Researchers in such fields as education, urban poverty, unemployment, the control of crime and drug abuse, and even health have discovered that successful outcomes are more likely in civically engaged communities.*

4.1.2 Targeted community prevention efforts

As a way to prevent alcohol and drug problems among youth, Hawkins, Catalano and Miller (1992) suggest that a successful intervention needs to consider not only changing an individual's behavior, but also the norms and behaviors within the family and community in which that individual resides. Neighborhood risk factors that need to be addressed include laws and norms favorable toward use, substance availability, extreme economic deprivation and neighborhood disorganization. These are combined with family-level changes (family alcohol and drug behavior and attitudes, poor and inconsistent family management practices, family conflict and low bonding to family) and school-related reforms (academic failure and low commitment to school).

Because not all of these factors can be changed, Hawkins, Catalano and Miller recommend that bonding to family, school and peers can serve as a protection against risk behaviors among youth. Their recommended prevention strategies emphasize the use of community mobilization strategies to increase protective factors while reducing risk factors. In their view, a healthy childhood depends on youth having strong social bonds to others who exhibit pro-social behavior. Community-based interventions are a means for addressing both "substance" demand and supply factors, as well as broader contextual issues such as community organization.

Search Institute's approach further exemplifies this perspective. Their research has found that risk behaviors in youth are related to "assets" that reside both within the young person and throughout the community. The uniqueness of this approach is its emphasis on developing the positive strengths in youth rather than focusing on problem behavior. Efforts to mobilize communities are "grass-roots" in orientation and designed to involve multiple sectors of a community:

> *Ultimately, rebuilding and strengthening the developmental infrastructure in a community is not a program run by a few professionals (though they are certainly part of the team). It is a movement that creates a community-wide sense of common purpose, placing*

community members and leaders on the same team moving in the same direction. In the process, it creates a culture in which all residents are expected and empowered to promote the positive development of youth (Benson, 1995, p. 11).

4.2 The Colorado Trust's Approach to Building Community Capacity

Over the past six years, The Colorado Trust has developed seven community-based initiatives that, at least in part, seek to build capacity. The specific issues targeted by the initiative range from violence to teen pregnancy to health education. In some cases, the foundation's support is directed at a specific organization — either a nonprofit organization or a local government agency — while in other cases, an effort is made to mobilize the community at large around important health issues.

The Trust's style in working with community-based groups is to act as a partner in the capacity-building process. At the beginning of an initiative, The Trust's role tends more toward the dissemination of models, ideas and technical assistance. For example, in the Colorado Healthy Communities Initiative (CHCI), each of the 28 participating communities was presented with a specific model — developed by the National Civic League — for exploring the community's health issues and identifying promising solutions. Outside facilitators guided a representative group of community "stakeholders" through 16 months of meetings, ending with an action plan submitted to The Trust for funding. The initiative introduced communities to a new way of thinking about "health" (based on the World Health Organization's broad definition) and a new approach to decision-making (involving volunteers from throughout the community who worked toward consensus decisions). This form of intervention was designed to build capacity in terms of new skills, new leaders, stronger relationships, more open exploration of the issues and a deeper commitment to promoting the higher good of the community.

Most of the initiatives developed by The Trust introduce a model or idea to communities in order to provoke a new approach to community problem-solving. More recent initiatives have employed less prescribed, more tailored tools and procedures than occurred under the CHCI. For example, the Violence Prevention Initiative (VPI) provided grantee organizations with a project consultant who worked with local staff to determine the underlying risk factors for their violence-related issue, and then to identify promising prevention programs that would address those risk factors. The initiative vested the choice of intervention with the grantee organization, while at the same time providing a wide array of technical assistance (e.g., program planning, evaluation, organizational development) and access to a database of promising prevention programs. Again, the emphasis was on helping local individuals and organizations develop their own capacity (e.g., leadership, knowledge and relationships), but in contrast to the CHCI, the approach in the VPI involved much more joint problem-solving between the initiative's consultants and the staff of each funded organization.

The tools and services provided to grantees by the funder are an important element in the building of community capacity, but these are only the starting point. As The Trust's community-based initiatives have evolved, we find that grantees come up with their own tools to continue the capacity-building process. For example, in the CHCI, representatives from the 28 communities presented The Trust with a proposal to form a network that would allow them to share ideas and coach one another. The Colorado Healthy Communities Council (as the network came to be known) has developed a number of new tools to help communities strengthen their "healthy community" efforts, including conferences, computer listservs, and a grant program that uses peer reviewers to critique and support one another.

The strategy of establishing networks among grantees has proven effective in many of The Trust's community-based initiatives, which reflects the "messiness" of this sort of work. Although "model programs" exist for addressing health problems such as violence, teen pregnancy, substance abuse, child abuse and low birth weight, the process of carrying out health-promotion work at the local level is never straightforward. Training manuals and protocols go only so far in guiding community-based organizations as they cope with the real-world issues of recruiting

clients and volunteers, the cultural appropriateness of services, staff turnover and burn-out, community conflict and sustaining projects over time. Networks address this need by allowing grantees to share their lessons with one another, to bring in resource people who can provide additional insights and to work for changes at the state or federal level that support local health-promotion efforts. In short, networks provide community-based organizations with the opportunity and the responsibility to continue the capacity-building process over the long term.

One of the most important lessons The Trust has learned about building community capacity is that this is a developmental process — the way in which a foundation supports community-based organizations should evolve as those organizations succeed in becoming more capable. For example, the healthy communities planning model that The Trust and the National Civic League introduced to Colorado in 1992 would not prove as useful if it were offered again in 1998. As individuals and organizations mature, different forms of capacity become more essential. For example, during the initial stage of the CHCI, there was no mention of the idea of a "learning organization," but the Colorado Healthy Communities Council recently identified this as one of the fundamental principles that define the concept of "healthy communities." As communities become stronger, their potential for effective action increases, but so do their expectations. For a foundation to remain relevant in the capacity-building business, it must listen to and learn from its grantees. In other words, as communities develop more and more capacity, the foundation must do the same, or risk becoming irrelevant.

5. Moving Past the Medical Model for Promoting Health

The research reviewed here shows that community capacity is a strong determinant of health. In other words, a healthy *community* leads to a *healthy* community. This means that health-related organizations (including foundations) can advance their missions with strategies that effectively build community capacity — for example, by developing the skills and leadership of local residents, by convening forums that strengthen the relationships and commitment of local residents and by promoting a culture of learning and growth. However, as Marshall Kreuter points out, only a few organizations take advantage of these sorts of opportunities for health promotion:

> *In spite of the extensive literature pointing to the social, economic, and political determinants of contemporary health problems, we see few instances of resources being ear-marked for building or strengthening the community capacity to implement [community-based health-promotion strategies]. This is somewhat akin to the "batteries not included" caveat* (Kreuter, 1998, p. 3).

Kreuter goes on to argue that funders, in particular, need to pay more attention to the role that community capacity plays in fostering effective health-promotion efforts:

> *If valid measurement can show that social capital or some aspect of community capacity is clearly linked to the effective application of community-based public health programs, funders will have to re-examine their present policies. Specifically, funders would be able to make more informed decisions about the most productive ways to contribute infusions of health-related funding to a given community — either to bolster the capacity that is requisite for successful interventions, or move directly to the interventions themselves* (Kreuter, 1998, p.3).

The Colorado Trust has in fact expended many financial and intellectual resources over the past six years developing and implementing strategies for "bolstering the capacity that is requisite for successful interventions." More and more of the new conversion foundations are also showing a strong interest in the capacity-building approach. This makes eminent sense from an economic standpoint. Foundations have

enough resources to invest in activities that strengthen a community's ability to solve its own problems (e.g., training, leadership-development, strategic planning efforts, dissemination of model programs, networking and community-building) but not enough to subsidize the widespread provision of medical services, especially on an ongoing basis. In a very real sense, the capacity-building approach to health-promotion is the most primary means of prevention.

Although community capacity represents an important mechanism for improving health status, it is by no means the only approach that should guide the work of health-oriented organizations. The research reviewed here shows that a population's health is determined by a number of distinct factors, such as the availability of medical services, the ability of the population to afford medical services, the quality of the local environment (e.g., air and water pollution) and the prevailing patterns of risky behavior (e.g., tobacco use or driving while intoxicated). Each of these determinants represents a potential leverage point for an organization interested in improving the health of the population. Foundations might, for example, subsidize medical care, pay the construction costs for a new clinic, support reform in environmental policy or develop a public-awareness campaign designed to change behavior. In addition, health might also be promoted by enhancing the economic resources of a community. For example, the Ford Foundation and the World Bank place a great deal of emphasis on economic development within poor countries, in part because a stronger economy brings up the health and well-being of local residents. None of these approaches, including building community capacity, is a magic bullet. Different organizations should focus on complementary pathways so that a comprehensive health-promotion strategy emerges throughout the community.

Knowing the pathways to health is only the first step to effective health promotion. There are tremendous challenges associated with achieving substantive improvements within whichever path an organization chooses to focus on — changing cultural norms, cleaning a community's air and water, making medical care more affordable and accessible, increasing economic prosperity or building community capacity. Moreover, strategies that worked in the past don't necessarily achieve the same success in today's more complex world. Foundations have historically played a vital role in developing innovations that support health promotion and other improvements in quality of life; questions such as, "How do we effectively draw out and build a community's innate capacities?" provide exciting new opportunities for innovation.

In the end, each conversion foundation must look at its own culture and competencies, as well as the landscape in which it operates, to determine the most appropriate approach to health promotion. However, regardless of what perspective the foundation adopts, its most valuable role in the health-promotion process may be in acting as a catalyst for change throughout the larger "system." No single organization, including a foundation, controls all the resources, behaviors, knowledge and relationships that influence health, but a foundation is in a unique position to draw out the ideas and talents that too often lie dormant when a community confronts its health threats.

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