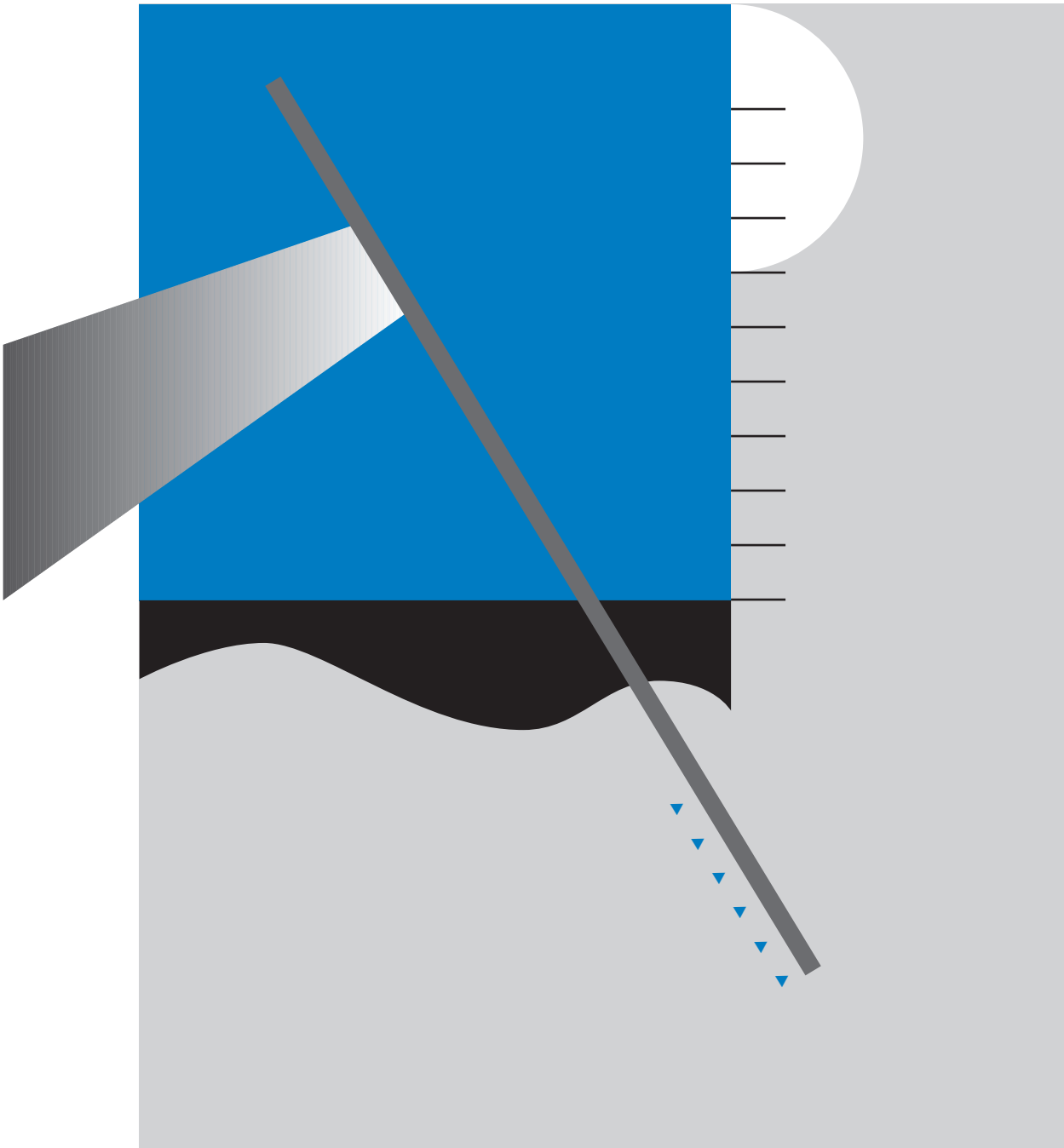
THE COLORADO TRUST

Promoting Health by Building Community Capacity

SUMMARY



Promoting Health by Building Community Capacity: Summary

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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. The complete report, *Promoting Health by Building Community Capacity: Evidence and Implications for Grantmakers,* describes this research in more depth and presents a broader framework for analyzing geographic variation in health status.

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.

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The Challenge for Conversion Foundations

Over the past decade, nearly every state in the United States 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, a merger, an acquisition or a joint venture. When such a conversion takes place, the proceeds are typically used to establish a new philanthropic foundation. These new "conversion" foundations typically adopt a mission that calls for promoting the health of whatever geographic region — city, county 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]

Assuming that these new foundations are motivated to be good stewards of their endowment, they will eventually ask themselves the question, "What is the most effective strategy for promoting the health of our population?" Given their origins, conversion foundations have a natural tendency to fund *medical* goods and services to the community (e.g., paying for the construction of health clinics or supporting programs that increase access to medical care among low-income populations). 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, 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.

This paper explores the nature of "community capacity" and its relevancy for conversion foundations. The perspective and strategies of The Colorado Trust are highlighted to provide a more concrete sense of what is involved in building community capacity both in terms of the process and the potential benefits.

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, 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 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 within their grant applications, The Trust plays an active role in the program-design process. In particular, foundation 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 develop-

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.

ment and evaluation of programs that provide home visitation services to young, at-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) Building the capacity of nonprofit organizations to select, plan, implement and refine effective programs (e.g., violence-prevention programs and home visitation programs).

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 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.

The Nature of Community Capacity

A number of researchers, nonprofit organizations and foundations have begun to focus on community capacity as an important leverage point in improving local quality of life (Aspen Institute, 1996). However, *community capacity* is an elusive construct with varying definitions. The work of The Colorado Trust provides one framework, but certainly not the only framework, for thinking more concretely about this concept. In particular, when The Trust has attempted to build community capacity with its grantmaking, 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.

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. Because of the traditional emphasis on *marketable* skills, we often overlook many important 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 promotes community well-being develops naturally through the course of our work and personal lives. However, some of what would help the community — knowledge about "programs that work" and skills related to public awareness, program development, research, strategic thinking and the like — must be learned outside the scope of everyday experience. The Colorado Trust's initiatives strive to build these sorts of capacity, not by bringing "experts" into the community to do the work, but rather by teaching and encouraging local residents. Each community comes into an initia-

tive with myriad talents, 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.

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 local residents and organizations achieve their full potential (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 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.

A Sense of Efficacy

Health promotion ultimately requires *action* — either at the individual level (adopting healthy behaviors), at the family level (creating a nurturing home environment) or at the community level (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.

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. 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.

Social Capital

One of the most well-developed dimensions of community capacity is "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. All these examples point to relationships that 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.

Culture of Openness and Learning

The last dimension of community capacity 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. For authentic learning to occur, the culture must do much more than politely acknowledge intracommunity differences. 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).

This sort of open 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 framework, 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 prove 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.

The Relation of Community Capacity to Health

Community capacity, as defined on page 4, 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 activities that promote health. 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.

Modeling Geographic Variation in Health Status

The evidence showing that community capacity influences health builds on a larger, more established body of research that explores geographic differences in health status. It has been long recognized that levels of health vary dramatically between neighborhoods, cities, counties, states and countries. For example, in 1995, the infant mortality rate in Massachusetts was 5.2 deaths per 1,000 births, while in Mississippi it was double that at 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; the rate of low-weight births varies from zero percent to 20 percent throughout Denver's neighborhoods.

Statistical techniques such as multiple regression analysis can be used to identify the factors that account for geographic variation in health status. With this form of analysis, 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, 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 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 a very real sense, the explanatory factors that emerge as significant from these analyses point to the underlying determinants of health. The Bird and Bauman (1995) study showed that the *causes* of infant mortality include the economic health and educational infrastructure of the state, not simply a lack of health-care resources. An extensive set of research shows that environmental, cultural and economic factors each play an important role in determining a population's health.[2] More recent research, reviewed next, suggests that community capacity also influences the health status of a place.

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 study attempted to explain between-state differences in a number of mortality measures (e.g., age-adjusted mortality and infant mortality) using a set of predictors that measured each state's *civic engagement*, trust and helpfulness. The analysis found that states with higher levels of civic engagement (i.e., where residents belong to more voluntary groups and associations) have lower overall mortality rates and lower rates of mortality from heart disease and malignant neoplasms. Social trust (measured by asking a sample of residents in each state whether they trusted people) provided even stronger predictive power, accounting for 64 percent of the variance in overall mortality as well as showing significant relationships with four 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.

Infant Health Depends on Neighborhood Resources

Another set of studies shows that the health of infants is influenced by the social and economic neighborhood contexts in which their mothers reside.

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 economic hardship (i.e., neighborhood unemployment and poverty) and higher housing costs were found to increase a woman's chance of having a low-birth-weight child, living in a neighborhood with a higher proportion of black residents brought down the rate, conferring a "protective influence." 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 postneonatal mortality (i.e., death occurring after 28 days but before the end of the first year of life) 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.

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." *Social cohesion* and trust were 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. The researchers also asked local residents

2. These studies are reviewed in the full version of this paper, *Promoting Health by Building Community Capacity: Evidence and Implications for Grantmakers*, available from The Colorado Trust.

about their willingness to intervene in threatening situations (for example, if children were spray-painting graffiti or a fight broke out in front of their house). Neighborhoods where more residents responded affirmatively to these questions (neighborhoods with higher levels of collective efficacy) tended to have lower rates 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.

The Challenge of Building Community Capacity

The empirical research reviewed here indicates that at least some aspects 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, 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).

Although 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 (Wallis and Koziol, 1996). John Kretzmann and John McKnight (1993) pioneered much of the activity in this area. They advocate that communities use their existing assets as a path to community development. The talents of locally based group 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.

The Colorado Trust 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 initiatives 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. 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 acting toward the higher good of the community.

More recent Trust 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 rela-

tionships), 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, 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 because the 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. As individuals and organizations mature, 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.

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, Marshall Kreuter argues that 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).

On the other hand, a host of new conversion foundations are showing an 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.

Community capacity represents an important mechanism for improving health status, but it is by no means the only approach that should guide the work of health-oriented organizations. The health of a community 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 and the prevailing patterns of risky behavior. Each of these determinants represents a potential leverage point for an organization interested in improving the health of the population. Different organizations should focus on complementary pathways so that a comprehensive health-promotion strategy emerges throughout the community.

In the end, each foundation must look at its own

culture and competencies, as well as the landscape in which it operates, in determining 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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