



COMMUNITY PARTNERSHIPS
for HEALTHY CHILDREN

An Initiative of Sierra Health Foundation

**A 10-Year Investment in Community Building
to Improve Children’s Health:
Evaluation of the Community Partnerships
for Healthy Children Initiative**

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Dear Reader:

In 1993 when Sierra Health Foundation announced its Community Partnerships for Healthy Children (CPHC) initiative, community building to improve health was not commonplace. At the time, many foundations were primarily funding the delivery of services, and government program approaches did not routinely include soliciting input directly from community residents. The concept of improving children's health by focusing on building stronger communities was not generally on the front burner.

Ten years later, as our initiative comes to an end, some things are the same. Once again, the economy is stagnant and budgets at all levels of government are in crisis. California's population is growing, in both numbers and diversity, and the state's infrastructure is stretched to accommodate the growth. In communities everywhere, much needs to be done and there are too few resources to address all needs.

Other things, however, have changed. Across the nation, community building is becoming more recognized as an effective technique for engaging people and addressing issues. More foundations, community organizations and government agencies are beginning to understand the value of forming partnerships with residents and leveraging resources. Good ideas are abundant, but bringing those ideas to scale then sustaining them, as always, is challenging.

At Sierra Health Foundation, we have completed the evaluation of our 10-year, \$17 million experiment with community building as an approach to improving children's health. This report shares the results of that evaluation and other lessons learned for four key audiences: community activists, funders, technical assistance providers and evaluators.

In addition, this report tells a story for policymakers – both public and private. Our experiment did not always perform as we expected it to, but in the end it was clear that something very valuable happened in each community involved in the initiative. Investing in community building pays off. The results may be slow, diffused and difficult to measure, but in many ways community building makes communities better places to live and, therefore, places more capable of raising healthy children.

For those who want more detail, a formal evaluation report is available, as are five years' worth of newsletters that tracked the progress of communities involved. In addition, a set of publications provide a step-by-step outline for using a community building approach. Our hope is that this report inspires further community building efforts throughout California and the nation.

Len McCandliss

President, Sierra Health Foundation

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Introduction

What is the most effective way to improve the health and well-being of young children in diverse communities that are facing a variety of challenges? What if some communities are crowded urban neighborhoods and others are isolated rural settings? What if some have strong Hispanic or African-American influence, while others are dominated by Asian or Slavic languages and cultures?

Any single approach is unlikely to fit each community's specific needs. Even if a one-size-fits-all solution could be identified, the resources to implement it on a massive scale simply are not available.

In 1993, Sierra Health Foundation set out to see if community building – a bottom-up rather than top-down approach – could make a difference in children's health and well-being in northern California. The Community Partnerships for Healthy Children (CPHC) initiative invited communities to form collaboratives, learn assessment and planning techniques, implement activities and programs, and evaluate results. The initiative, which focused on children from birth through age 8 and their families, was guided by a set of principles and goals that emphasized prevention and community-based solutions (see box).

The concept was to mobilize residents to use a community's assets for the common good. A community's assets include the capacities, skills and talents of its residents; the network of its local civic and voluntary associations; and the resources of its local agencies and institutions. Communities were provided both grants and intensive technical support to achieve the goals of the initiative and to promote the development of local power and voice.

Overall, a total of 31 communities participated in the initiative. Due to the challenging, long-term nature of CPHC and the relatively small grants, Sierra Health Foundation fully expected some communities to withdraw along the way. Initial estimates were that about half the collaboratives would leave the initiative at some point. Twenty-six communities remained through phase three, with 18 engaging in a final fourth phase.

Grant amounts to CPHC collaboratives for each phase of the initiative were kept purposely small to encourage community volunteer participation and to create sustainable activities and programs. CPHC grants were not large enough to fund staff salaries and community work. Grants primarily supported community organizing and collaborative management. Activities of the collaboratives were generally volunteer-based or supported by other local resources.

Over the 10 years the initiative was in place, Sierra Health Foundation provided over \$17 million in funding. This included funding for two organizations to provide support to the collaboratives. The Center for Collaborative Planning provided training and technical assistance on collaboration, asset-based community development and action planning. SRI International conducted the evaluation of the initiative and provided training and technical assistance on evaluation to the grantees.

The result – as you will read in the following pages – was a qualified success. At a minimum, CPHC demonstrated that community building can make communities better places to live. Given the right circumstances, it also appears that community building can improve select health outcomes.

CPHC Goals

To improve the health and well-being of children and their families in the Sierra Health Foundation region (inland northern California).

To assist the communities in the region to identify the needs of children and families and pursue new opportunities to address these needs.

To develop and strengthen the organizations and systems that respond to the needs of children and families.

To develop solutions to the needs of children and families by maximizing the use of existing financial resources and services through increased efficiencies and/or the reallocation of resources and, where necessary, by developing new resources.

To achieve a lasting, positive impact on the ability of communities to respond to and organize around children's needs.

CPHC Principles

Parents and families, supported by community resources, are first and foremost responsible for the healthy development and care of their children.

When appropriate, emphasis should be given to prevention of and early intervention for preventable conditions.

The physical and mental health of a child is affected by a wide variety of factors, family quality of life being the most significant. Other factors that can also influence child health include the environment, heredity, medical condition and treatment, culture and geography.

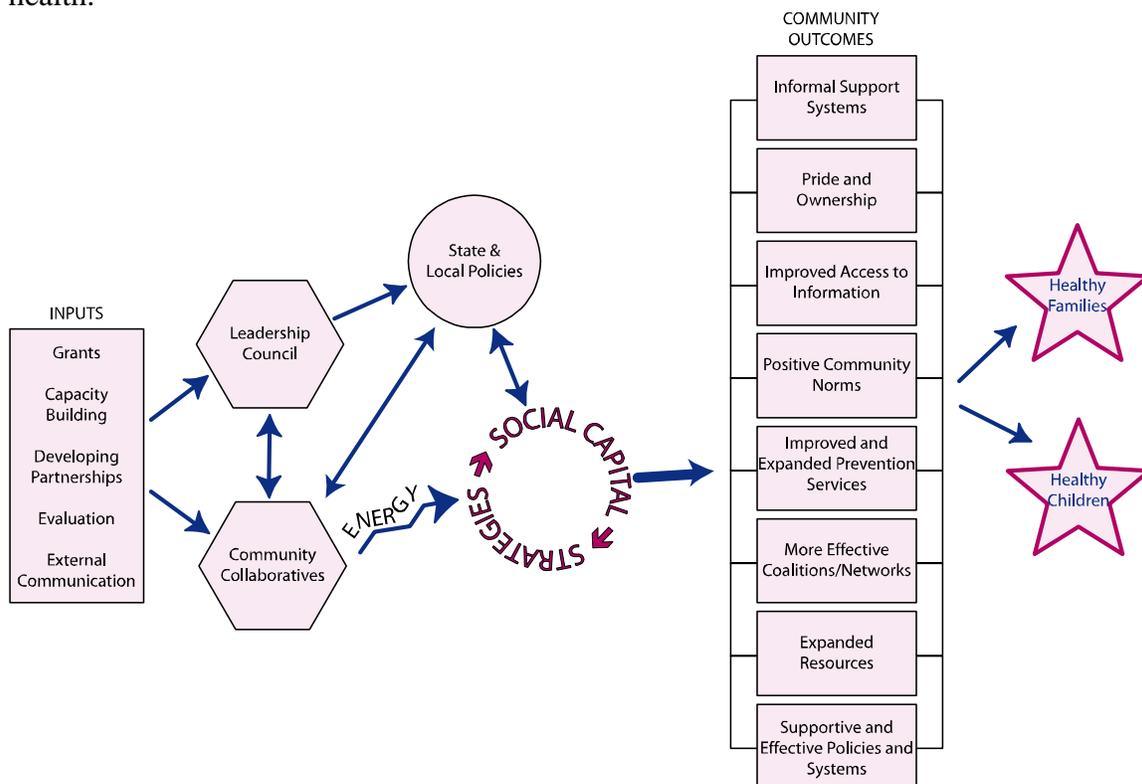
Effective solutions to the needs of children and their families require collaboration among decision-makers, providers, advocates and consumers that represent the diverse interests of the community.

Initiative Framework

The CPHC initiative was an experiment to learn if community building could be used as a tool to improve the health of children. Individuals and organizations were to work together to identify the critical health-related issues for children in their communities, design solutions using community resources and implement them.

The design of the initiative recognized the potential power of people working together around a common goal. Over the course of a decade, CPHC would attempt to answer three questions: Could communities mobilize their resources for the good of children? Could effective strategies be implemented? And could the health of children be improved?

A graphic representation of the framework for the initiative was developed (see below) to show the inputs, the intermediate results and the expected long-term outcomes. This framework illustrates how the formation of collaboratives was expected to bring about strategies that both built and used social capital. Social capital, the glue that holds a community together, is made up of the interactions among people and organizations, working collaboratively in an atmosphere of trust, that lead to a goal of mutual shared benefit. The graphic also illustrates that these strategies would produce important outcomes for the community, and that these outcomes in turn would result in improved health.



The initiative included four phases:

Community Development: During this phase, communities were expected to establish a collaborative, conduct a community health assessment, reach conclusions about the health and well-being of children and families, select issues to be addressed, and develop a program planning proposal.

Program Planning: This phase focused on the development of a Strategic Action Plan designed to address the health issues identified during the Community Development phase. Collaboratives involved communities in identifying solutions to the issues and in selecting corresponding indicators that would track the impact of strategies once they were implemented.

Program Implementation: Collaboratives carried out different strategies and activities during implementation, ranging from public education and outreach to community events, recreational opportunities and after-school care.

Impact and Sustainability: This phase, added in year seven as the initiative was coming to the end of the initial planned timeframe, was designed to increase the sustainability and effectiveness of collaboratives. The goal was to lay the groundwork for sustaining the principles and goals in these communities beyond 2003.

Phase One - Community Development

It takes the resources and dedication of many groups (residents, health care providers, service agencies, neighborhood and parent associations, schools, clergy, art organizations, etc.) working in collaboration to strengthen families for the benefit of children.

In addition, a major operating tenet of CPHC was that solutions are most effective when initiated by those most affected by the problem the solution is addressing. For these reasons and others, the collaborative concept of bringing a cross-section of each community together became the key to achieving the goals of the initiative.

The Vision

The first step was for each community to establish a collaborative. In some instances, collaboratives already existed, either formally or informally; in others, the communities were starting from scratch. Each collaborative was to be broad based and diverse, providing an authentic voice from all segments of the identified community.

The second step was to conduct a community assessment that documented strengths (or assets) and needs. This would provide a baseline understanding of the issues affecting children and their families in the community, as well as the assets available to address the needs. Collaboratives were asked to compile both quantitative and qualitative data on child and family health issues. They were encouraged to seek out non-traditional sources of information and to collect their own data through focus groups, key informant surveys, community forums and community surveys.

The next two steps were interrelated. The collaborative was to reach conclusions about the health and well-being of children and families based on the assessment. From that process, a Child and Family Health Profile, describing key problems, trends and issues, was developed and circulated within the community.

Finally, the collaborative was to select issues to be addressed based on the community assessment and develop a Program Planning proposal. At this point, the issues that were most critical to children and families had been raised and validated in community meetings and forums. They were not to be someone's pet project or a gut feeling about what was needed; they were to be issues that had been identified in an inclusive, systematic way.

What Happened

- ✓ ***Communities were able to establish new collaboratives or adapt existing collaboratives. Numerous factors helped or hindered the success of the collaboratives.***

All communities formed collaboratives, but differences were striking. For example, geography impacted how collaboratives operated. When a large number of square miles were included in a "community," there were significant logistical barriers (driving

distance, lack of public transit) to full participation. More compact communities – towns and neighborhoods – could easily bring people together. On the other hand, county-wide collaboratives had easier access to county-level resources.

Collaboratives also differed in regard to human capital, which turned out to be critical to success. Some collaboratives had members with many skills, while others needed training for all aspects of the initiative's process. Although a central theme of community building is that all residents bring assets to the table when they participate, it is also true that some assets (e.g., writing skills, public relations knowledge, computer expertise, grant-writing experience, etc.) are more valuable than others in a collaborative's day-to-day existence and eventual sustainability. Collaboratives that possessed these specialized assets had distinct advantages over those that did not.

Finding and retaining a capable coordinator also turned out to be a critical success factor. Some collaboratives had strong and consistent leadership, while others were plagued with turnover. Some had a single, central leader who contributed time and energy extensively. Others had a number of leaders who shared the workload and could provide a smooth transition if one individual left.

✓ ***Finding the right balance in collaborative membership between agency representatives and community residents was important and challenging.***

The Foundation actively promoted having more resident members in collaboratives because of a concern that having too many agency representatives would drive a collaborative's agenda in a direction that was not necessarily diverse and inclusive. Indeed, this occurred in some collaboratives, with coordinators reporting that the political and power structure of agencies often imposed a barrier to developing relationships – especially when agency goals did not match those of the community-driven collaborative.

However, bypassing agencies would have ignored the substantial resources that they could bring to the collaborative. Agencies made significant contributions to the success of collaboratives, including providing space, clerical support, supplies, phone lines, etc. The proportion of agency members proved to be less of an issue than an agency's ability to be open to community residents' concerns. Those collaboratives with significant connections to agencies that supported a resident-driven agenda could tap into resources that were unavailable to other collaboratives.

✓ ***The Foundation's substantial investment in capacity building proved essential to the success of the initiative.***

The Foundation invested significantly in training and technical assistance in each phase of the initiative. Communities received training in building and maintaining collaboratives, in conducting community assessments, and in developing Strategic Action Plans and evaluation plans. Individuals developed skills in leadership, advocacy, networking, report writing, administration, planning and evaluation, as well as in gaining access to agencies and information. Trainings were based on the "train-the-trainer" model

to foster leadership development, build individual skills, and spread knowledge to other community members.

Throughout the initiative, coordinators repeatedly identified the technical assistance received as one of the key factors responsible for the success of their collaboratives. The regular convening of the coordinators over the years also built a network of people engaged in similar work and provided a source of social support and information.

The commitment to intensive training was not easy. Challenges included the large number of grantees; lack of uniformity of progress through the phases (which meant different groups of individuals could not necessarily be brought together for training); geographic distance (i.e., those providing training were located in Sacramento while those who needed training were dispersed throughout northern California, sometimes spanning great distances even within one collaborative's territory); the diverse array of issues chosen by collaboratives; and the relative inexperience of the members in some communities. Nevertheless, despite the challenges, the investment in training and technical assistance proved key to what collaboratives were able to accomplish.

Community Development Grants

Initial grants were up to \$37,000.

Funds were to be used for:

- establishing or expanding a collaborative;
- assessing needs and strengths of the community;
- identifying the most critical health issues facing children and families.

Nineteen Community Development grants were awarded in May 1994, two in October 1994 and eight more in January 1995.

Two communities began the initiative in Phase II, Program Planning.

Flashback: West Modesto

Carole Collins remembers the early days in 1995 when West Modesto/King-Kennedy Neighborhood Collaborative was just getting started. Although the area the collaborative covers is small – only 1.2 square miles – the population is diverse. Within its 8,300 people are African-Americans, Hispanics, whites, Hmong, Laotian and Cambodian residents.

“We presumed from the beginning that everyone had to meet separately because of all the different languages,” Collins says. But it wasn’t long before the residents said that if anything was ever going to be accomplished for the community as a whole, then all of the groups would have to meet together as a community. The collaborative lined up interpreters.

“A one-hour meeting would last two or three hours because we would translate everything into each language,” Collins says. “Someone would hold up a little stop sign and that was the signal for the interpreters to get busy. We simply kept at it until everyone in the room understood everything that had been said.”

The commitment to inclusiveness paid off in a mobilized community supporting a collaborative that during one 15-month period drew more than 450 families to meetings.

Tips for Activists

Being inclusive takes time and patience. The end result is usually a stronger plan that has broad-based support from the beginning.

Successful collaboratives need a number of “weight bearers” to share the workload and provide continuity when leadership changes.

Different members make different contributions. Some will attend meetings; others will pitch in at an event; still others will do outreach by phone or in person.

The measure of a successful collaborative is not necessarily how many members it has – and certainly not how many attend a meeting – but how many people are mobilized for the good of children and families.

Tips for Funders

Funding a smaller number of collaboratives and keeping them all on the same schedule makes an initiative easier to manage but forces collaboratives to stay on an externally imposed, artificial timeline that could weaken collaboratives and undermine community building.

Funding cohorts of grantee communities in staggered cycles allows lessons learned from earlier funding rounds to be incorporated into subsequent rounds.

Funders need to be prepared to invest heavily in capacity building for initiatives that target community residents and expect them to carry out the activities.

Funders need to find the right balance between intervening in the operation of struggling collaboratives and letting them work through the inevitable challenges that will occur.

Funders need to be clear from the beginning on what parameters of an initiative are non-negotiable and must be adhered to by all grantees.

Lessons Learned

Collaborative success was influenced by a variety of factors, including geography and membership capability.

Balancing membership between agency representatives and community residents was important; both brought important contributions to the process and neither could be ignored.

Training and technical assistance was not always easy to provide but it was critical to the success of the collaboratives at all stages.

Phase Two - Program Planning

The second phase of the CPHC initiative was Program Planning, which focused on the development of a Strategic Action Plan. Since CPHC was not focused on a pre-defined issue, each collaborative selected issues and designed strategies that reflected the community's priorities. The result was a wide range of approaches to improving the health of children and families.

The Vision

During the Program Planning phase, collaboratives were to actively involve their communities in identifying solutions to the issues they had selected in the Community Development phase. The solutions were to be incorporated into a Strategic Action Plan that would serve as the basis for the implementation proposal for the next phase.

In addition, collaboratives were asked to identify a set of desired outcomes, select corresponding indicators that would measure progress, and collect baseline data about the indicators so they would be able to assess the success or impact of their implementation efforts. Collaboratives were required to seek input from the community and then return to the community for feedback and validation throughout the planning phase.

As part of the technical assistance, collaboratives were trained in community resource mapping, strategic planning, development of outcome statements and collection of indicator data.

What Happened

- ✓ ***Allowing collaboratives to identify issues of most concern to them generated strong support for the work to be done but at times resulted in broad efforts that were not targeted enough to be effective.***

In keeping with the spirit of a resident-driven agenda, each community selected its own issues. Some communities selected one issue on which to focus their efforts. For example, Grassroots for Kids in Shasta County selected “recreational opportunities for children.” Others selected several issues, some of which were very broad and not closely connected to each other or to children birth through age 8. The San Joaquin County Healthy Children's Collaborative selected nine issues, including lack of communication, lack of safety and security, lack of employment, education, child care and nutrition. Collaboratives that set out to address many broad issues had a more difficult time developing an action plan and finding strategies that were likely to be effective than those that set their sights on a single, more narrowly focused issue.

One of the principles of CPHC came through clearly in issue selection – that the physical and mental health of children is affected by a variety of factors. But the result was that the issues selected often went far beyond even the broadest definition of health. In

addition, collaboratives had difficulty keeping their focus on children birth through age 8, often including whole families in their plans, regardless of children's ages.

Over time, it became clear that collaboratives would have benefited from parameters that allowed them leeway but still assisted them in identifying issues that were manageable enough to be impacted by community-based strategies.

✓ ***Collaboratives were able to develop action plans but the planning process proved challenging.***

In theory, the planning process was an opportunity to repeatedly engage members of the communities in various kinds of activities that focused on identifying and directing their community's assets toward solutions for the issues identified. In reality, the process was difficult to carry out because it was lengthy, complicated and focused on getting ideas down on paper rather than on taking action. This was frustrating for collaborative members who wanted to get busy and make a difference in the community. The Foundation responded with a program of mini-grants that allowed communities to implement small projects during planning.

✓ ***Some Action Plans better incorporated more proven, effective practices and approaches. Consequently, some had a higher probability of impacting child health than others. The process of developing the plan, however, was important to the collaborative, regardless of the content of the plan.***

Some collaboratives elected to address challenging social issues and included a very large number of strategies and activities in their action plans, whereas others were more targeted. Collaboratives often did not have the expertise to research what was already known about effective strategies. Although the guiding principle that "communities know best" had value in terms of community mobilization, the role of expertise and proven best practices is important, especially for designing solutions for complex issues like child neglect or drug abuse.

However, the process of working together to design and eventually implement activities was an important community building tool. The process provided an opportunity for people to work on a common problem, to get to know each other, to give of their time for the good of their community, to acquire new skills and to build connections.

Program Planning Grants

Grants of up to \$70,000 for 18 months were awarded.

One Community Development grantee was not continued because it did not share the principles of CPHC. Another grantee left the initiative because of insufficient progress.

Due to the length of time needed for planning, some collaboratives felt the need for small action projects to sustain collaborative energy and momentum. As a result, grants of up to \$5,000 were awarded for action projects in the communities.

Flashback: Rancho Cordova

When the Cordova Community Collaborative for Healthy Children did an assessment of needs in Rancho Cordova, no one was surprised that health care topped the list. A largely low-income bedroom community for Sacramento, Rancho Cordova had no low-cost health care clinics.

Increasing immunization rates for school-age children was identified as an outcome that the collaborative wanted to achieve. The strategy was to build on existing partnerships and expand the services at a school-based clinic operated by Mercy Healthcare West.

At the collaborative's suggestion, Mercy partnered with the Folsom Cordova Unified School District to offer free immunizations to those without health insurance or government coverage.

Today, the clinic is staffed by a nurse practitioner during the week. Volunteer physicians staff the clinic Thursday evenings, and Wednesday is immunization day. With state funding, the clinic provides prescriptions for medicine to treat asthma and diabetes, the most common health problems that require medication.

The strategy of using partnerships paid off for the Cordova collaborative, as did selecting an indicator that was measurable. Working together, the community, the school district and Mercy have been instrumental in improving the rate of child immunizations.

Tips for Activists

Keeping plans narrowly focused and well-defined offers a better chance for achieving measurable outcomes.

Being inclusive and consensus-based does NOT mean adding everybody's input to a wish list; deciding what to leave out is as important as determining what to put on the list.

The iterative process of getting community input, forming a plan, testing it with the community and then revising the plan based on input takes patience – but it's worth it because the plan will have built-in support before implementation begins.

Collecting or locating data from which to plan can be difficult for grassroots organizations. Local colleges, universities and government departments can be invaluable sources of data.

Tips for Funders

Strategic planning requires providing grassroots organizations with considerable technical support, especially regarding researching models and approaches that have been shown to be effective.

Communities need to be encouraged to find ways to keep people engaged in a manner that matches their skills and interests.

More technical support will shorten and speed the process.

Planning activities can be given a lower priority than action-focused activities in a community.

The community may benefit as much from the planning process itself as from the resulting plan.

Simplify requirements whenever possible. Preparing grant reports and other written products is very difficult for developing grassroots organizations.

Providing parameters on issues and/or restricting the number of strategies may help collaboratives target their energies more effectively.

Support development of data collection methods for child health indicators in communities that do not have data available.

Funders can expedite the process with more research and planning support to tie strategies to desired community outcomes.

Lessons Learned

Giving collaboratives freedom to pick their own issues built instant buy-in – but it also made it difficult to keep choices reasonable and objectives achievable.

The planning process was recognized as valuable, but it was also lengthy and discouraging for those who wanted to swing into action.

Actions plans varied in terms of sophistication and feasibility; some were more likely than others to directly impact children's health.

Collaboratives were sometimes frequently guided in their activities by intuition rather than by strategic priorities and outcome goals.

Phase Three – Implementation

Collaboratives carried out many different strategies and activities during implementation, cutting across a wide range of possible content areas and approaches. It was an exciting time for CPHC – a time for collaborative members to roll up their sleeves, plunge into the community and begin to make things happen. But this phase also was not without challenges. There was pressure to do more than resources allowed. There were evaluation reports to write. And there were new opportunities to assess and embrace that took collaboratives in directions that had not been included in their Strategic Plans.

The Vision

Using their Action Plans as a guide, collaboratives were to implement their chosen solutions for the issues they had identified. They were to mobilize resources from within and outside of their communities to carry out these activities. At the same time, the collaboratives were expected to mature and become credible and powerful voices for children and families in the community.

Sierra Health Foundation's intent was that communities would be most compelled to mobilize around younger children, so the focus of CPHC became children from birth through age eight.

The selected communities were also expected to become a “learning community” – designing and carrying out local evaluation activities - and using the information for continuous modification of their strategies.

What Happened

✓ ***Collaboratives implemented a diverse array of strategies, and these resulted in many new programs, services and facilities.***

The strategies were consistent with the principles of CPHC in that they encouraged and supported parents to take more responsibility for their children, emphasized prevention, and reflected the wide variety of factors that influence children's health. Strategies in the areas of parenting education and health were prevalent, but other popular strategies were public awareness efforts, community/family events, recreation, and child care/after-school care.

The most common content areas for activities were health, family support, collaborative promotion/enhancement, recreation, school readiness/achievement, parenting and child behavior/development. Specific activities ranged widely, from one-time family events and regularly scheduled school site programs to ongoing information dissemination and application for other grants.

The addition of new service-related facilities and buildings in the CPHC communities was common. New family resource centers, health clinics and shelters for women and

children are now present in a number of CPHC communities as a result of the collaboratives' organizing and mobilization efforts.

Sierra Health Foundation knew that community members would need to receive professional training and assistance in organizing, planning and implementation to reach their objectives of improving children's health. They also would need assistance in designing and implementing their local evaluation plans. In preparation for that, Sierra Health allotted a significant portion of the CPHC budget to training and technical assistance.

✓ ***Many collaboratives entered into new activities that were not in their Action Plans.***

In addition to activities included in Action Plans, many of the collaboratives reacted to needs and opportunities as they unfolded. Some stayed focused on their original issue and plan, but several entered new territory on a regular basis. As the State's Proposition 10 (a tobacco tax initiative that earmarked funds for children's programs administered by county commissions) came on line, many of the collaboratives became active in the work of their local Proposition 10 commissions.

Others used the training from CPHC to strike out in new directions or create new networks of activists to work on issues that reached beyond their communities. One collaborative took the training it had received and formalized a network to pass that training on to other communities that were not part of the CPHC initiative (See Flashback: Cottonwood sidebar on page 29). Other collaboratives applied for grants using information they had gathered in response to CPHC requirements.

Sometimes a collaborative took a new direction in response to an emerging problem. As a result, the desire to achieve a set of pre-specified, long-term outcomes did not exert much influence on the day-to-day work of some collaboratives. However, this way of doing business was very effective for the collaborative in other ways. It provided high levels of satisfaction for the members, garnered respect from the community, contributed to community-building, and resulted in numerous concrete benefits to children and families.

Some of the new, unplanned activities had a direct connection with children's health. These included immunization projects, dental health screenings and development of indoor exercise areas to help children develop motor skills during the snowy months of winter.

Other activities were more tangential to health issues. For example, a community barbecue brought residents together; once they knew each other, they began to watch out for each other; soon they had created a network of support where there was only isolation before. These increased connections gave children more people to rely on and relate to, which – it could be argued – resulted in improved well-being for children and families.

Collaboratives produced positive changes in their communities.

In addition to implementing new services and programs, collaboratives reported other positive community changes. The following were identified as common changes not directly linked to a service or program:

- Agencies and institutions were more likely to seek resident input.
- Residents were better informed about services and community resources.
- Opportunities for people to get involved increased.
- Groups concerned about children worked together more closely.
- The community was better able to respond to needs as they arose.

✓ Collaboratives could not do all they wanted to do because of limited resources.

The average number of active members in each collaborative grew slightly over the years, but at the same time the scope of the collaboratives' activities and responsibilities expanded considerably. As a result, the collaboratives did not have the needed resources to continue to recruit new members and to implement strategies. The lack of resources was further intensified by the large number of strategies that many collaboratives sought to implement.

While the focus of the CPHC initiative was on children from birth through age eight, many collaboratives included efforts that addressed needs of older children, as well.

While communities may be more compelled to initially mobilize around the issues and needs of very young children, it is not long before these communities will broaden their interests to other children and the family as a whole. Additionally, many of the community organizing strategies cannot, and should not, isolate the young child from the rest of the family. Many collaboratives implemented strategies specific to young children, such as immunizations, but health clinics, domestic shelters and the like clearly address family members of all ages.

✓ Learning to conduct their own evaluations was challenging for the collaboratives, but the investment in capacity building, particularly in individualized technical assistance, resulted in collaboratives being able to plan, conduct, evaluate and refine what they were doing in their communities.

Besides implementing strategies, the collaboratives also began producing annual evaluation reports. Even with extensive training and technical assistance, conducting the evaluations stretched the capacities of the collaboratives. Since each collaborative was following different strategies and working toward different outcomes and indicators, each evaluation was unique. That meant training about evaluation in general could be offered but specific advice that addressed each collaborative's situation also needed to be

provided. Because data were not available and could not be directly collected for some indicators, proxy measurements had to be identified and used. Data analysis was challenging. Because of the difficulty of evaluation and its relevant disconnection from doing community work, many collaborative members preferred almost any other assignment to evaluation tasks.

In the end, however, many coordinators acknowledged that the discipline of the evaluation process and the data gathered helped the collaboratives to be more successful, particularly when other opportunities for community leadership or grant funding arose.

✓ ***The evaluation capacity of CPHC communities was greatly expanded through the initiative and is one of the long-term impacts on the communities involved.***

Similar to how communities prefer to act rather than plan, communities also came reluctantly to evaluation. The concepts were difficult to understand; relevant, measurable data was hard to come by; and turnover in collaborative members made retraining and relearning on evaluation necessary.

Evaluation occurred at two levels: initiative-wide and at each community. Collaboratives were to identify one or more members to lead the local evaluation effort. Generally, these individuals had little to no evaluation experience so the independent evaluator provided them extensive training and technical assistance throughout the initiative. The local data, along with information from evaluation case studies that were prepared on nine sites, fed into the overall initiative evaluation.

Collaborative members were taught about outcomes, indicators, evaluation methodology, survey and instrument development, analysis of data, communicating results and applying evaluation findings to improve strategies. Each collaborative, through a group process, prepared an annual evaluation report that was reviewed by the evaluator and submitted to Sierra Health. The quality of these reports and the application of the learning continually improved over the ten years of CPHC demonstrating an increased understanding of evaluation concepts and approaches and an appreciation for the importance of measuring a community's efforts.

✓ ***The provision of training and technical assistance proved to be an essential element of success for the participating communities.***

Throughout the initiative, community representatives expressed the importance of the training and one-on-one support in their community mobilizing, strategic planning, implementation and policy advocacy. As communities progressed at varying speeds, the once group trainings need to be modified to create more opportunities for individualized training. With mobility of community members, or as community members engaged or disengaged with the effort, the need for repeated training on a variety of subjects became evident. This was particularly true with evaluation training. In the end, the amount budgeted for technical assistance, evaluation and initiative management equaled the amount awarded to communities.

Program Implementation Grants

Grants of up to \$150,000 each for 34-36 months were awarded in this phase.

Three grantees did not progress to this third phase.

Twenty six communities remained in the initiative during the Implementation phase.

Flashback: Trinity County

When Trinity Kids First in far northern California completed its community assessment, the list of needs was longer than the then-identifiable resources. So from the beginning, the collaborative looked for ways to partner with others, leverage different funding sources, and think creatively about how to get programs up and running.

The first decision the collaborative made set the tone for what followed: The group focused its efforts around paraprofessional site coordinators at schools spread throughout the rural county who built strong relationships with families and with schools.

Eventually, these coordinators proved the value of building community capacity. Even after CPHC funding ended, they continued to search out new grants and new ways to support programs and activities in their areas.

In addition to creating the school-based framework, Trinity Kids First also focused on specific needs identified in the community. One huge gap was dental care, which was addressed by creating school-based dental services.

Another need was raising awareness about drug abuse and its impact not only on users but also on children, who were more likely to be neglected or abused in households with drug use. Trinity Kids First won a grant from the state to educate the public about methamphetamine dangers.

Still another need was for community recreation opportunities that would bring people together and out of the isolation that is common in rural areas with high unemployment and depressed economies. Trinity Kids First cultivated programs throughout the county, including:

Fishing Friends, a program that pairs adults with children for an annual fishing expedition.

Family Dances where children could only attend if they brought one or both parents.

Summer arts and crafts programs at school sites.

Today, Trinity Kids First continues its programs and activities, making new connections and using evaluation data from their efforts to take advantage of new opportunities as they emerge.

Tips for Technical Assistance Providers

Be clear about the purpose and goals of technical assistance (TA).

Don't bring your preconceived ideas of what the community needs and wants – Ask!

Involve the community in development of a technical assistance plan that offers a variety of ways and methods for learning.

Offer opportunities for peer learning that allow for participants to fully share their experiences and knowledge with each other.

Balance “mandated” TA by creating space for other issues and TA needs to come from the group.

Follow training activities with one-on-one technical support to help groups look for ways to apply the learning and tools offered.

Don't assume the community wants technical assistance – offer but don't push or you may run into resistance and resentment.

Work in partnership with the community to assess the effectiveness of TA and use the feedback to improve content, process, and tools as needed.

Encourage participation by a variety of people within the community so that learning is available to many rather than limited to a few.

Flashback: Sacramento

The Children First-Flats Network in a small but densely-packed neighborhood in Sacramento spent its first two years conducting assessments and planning, just like the other collaboratives. In the process, they forged relationships with the local school and health clinic.

Those relationships proved valuable when the collaborative was asked to help do something about the low rate of childhood immunizations. The Flats Network got funds from a local corporation, hired a bilingual nurse to work out of the clinic, involved the school in outreach to parents, and plastered posters in English and Spanish throughout the neighborhood.

The approach worked. Parents could take their children to the clinic whenever it was open, without an appointment, and immediately be given immunizations for free. The result was a doubling of the immunization rate in just a few years.

With that experience under its belt, the Flats Network next turned to the dental needs of children, establishing school-based clinics with parent coordinators to keep track of children and follow up with parents. Volunteer dentists screened children for oral health problems and dental hygienists applied sealants to their teeth.

With many activities under way, the Flats Network could have become impatient with the rigors of evaluation imposed by CPHC. But the group soon learned the value of surveys and reports. With all of the information right at their fingertips, they were ready whenever opportunities arose. For example, their data was used by the local Boys and Girls Club to submit grant applications and secure funding to build a nearby facility.

Tips for Activists and Funders

The fiscal agent and its ability to manage within a community-based initiative are important to the success of the collaborative.

As informal groups, the collaboratives needed to find organizations that could serve as fiscal agents. It was a challenge because some public agencies do not function well without being in control – and by the very nature of the initiative, the collaboratives needed to be driving the agenda. The ideal fiscal agent brought the necessary knowledge and skills and wanted to be an active partner in the collaborative, but was comfortable with not having exclusive control.

Lessons Learned

When collaboratives are allowed to fashion their own agenda, the result is a diversity of strategies and activities.

As time goes on, a maturing collaborative will become involved in activities not originally envisioned. This is both a source of strength and a distraction.

Collaboratives are able to produce positive change in communities – among them, more involvement by residents and closer working relationships among those working on children's issues.

Needs and proposed solutions invariably grow faster than collaborative membership and resources.

Evaluation is technically difficult and rarely a popular use of a volunteer's time – but well-done evaluations can improve the collaborative's strategies and open the door to other opportunities.

Building the evaluation capacity of community members can have lasting impact on the community.

Phase Four - Impact & Sustainability

A final phase of the CPHC initiative was added as two realizations became clear. The first was that collaboratives needed to expand their activities if they were going to have a significant impact on children's health. The second was that without a focused effort, collaboratives would not continue to exist after CPHC funding ended. Thus, the final phase focused on increasing the impact of collaborative efforts while ensuring that those efforts continued.

The Vision

In the fall of 1999, the Foundation decided to continue to support CPHC for two more years and at the same time support the development of a CPHC Leadership Council. This body of CPHC leaders was expected to take on the stewardship of CPHC after the Foundation's direct grant commitment ended. The goals of the fourth phase were:

- Increase the number of children and families whose health was positively affected by the initiative's efforts by identifying, developing and implementing strategies that would change systems or influence local policies.
- Increase the sustainability of viable and vital CPHC community collaboratives by developing and implementing a post-initiative plan.
- Lay the groundwork for sustaining CPHC principles and goals beyond 2003 by creating a structure for self-governance, mutual support and management.

It was also the intent that CPHC community collaboratives and the assets and programs that were developed under the initiative would be sustained beyond Sierra Health funding. "Sustainability" could take several forms. If funding was received to continue activities and programs started by the collaboratives, that was one form. If programs were spun off and absorbed by another entity that was another form. If policy was enacted to give long-term permanence to programs and services then that was a third. And finally, if the community collaboratives of trained, committed residents remained to address new issues as they emerged in the community that was a fourth form of sustainability.

What Happened

- ✓ ***Collaboratives differed in the extent to which they were ready to embrace policy work. Some made the transition easily; others were not ready to make the shift.***

By this time, many of the collaboratives were well established in their communities, connected with other organizations and widely recognized as organizers or providers of activities, programs and services. Although recognition and acceptance of the importance of policy work were widespread, some of the collaboratives were reluctant to move from the type of work they were doing. Some wondered why the shift to policy work had to mean a shift away from services and/or activities. The capacity to carry on multiple functions was severely limited in most collaboratives, and the collaboratives' work in bringing about new services was highly regarded. Nonetheless, there was a widespread

recognition of the importance of policy work. Interviews with collaborative coordinators indicate that the training provided on policy and advocacy was highly valued and essential to their being able to engage in policy work.

✓ ***Although all of the collaboratives engaged in policy work during the two years of the fourth phase, much of it was relatively minor in scope and local in focus.***

Policy change can occur at many levels and have different degrees of impact. Requiring the use of car safety seats statewide to reduce child injuries in crashes is a policy change – but so is keeping the local clinic open in the evenings so working parents can access it. Many collaboratives had already accomplished some policy changes as an outgrowth of their Action Plans even before the final phase began. These strategies included improved lighting, highway safety projects and banning alcohol at local public events. Now they were required to form specific plans around policy, a difficult assignment when some of their previously selected issues may not have lent themselves to readily identifiable policy solutions.

In reports on successful policy impact efforts, collaboratives provided examples that ranged from new attitudes to specific changes. A common theme was that local policymakers were now taking time to listen to residents' opinions and seek their input before making decisions. Other examples were instituting new nonsmoking policies, influencing Proposition 10 spending decisions and developing juvenile drug courts. Collaboratives also reported contacting elected representatives about issues of concern.

✓ ***Community building occurred in all of the CPHC communities but took different forms in different communities.***

The continuing existence of the collaboratives after Sierra Health Foundation's funding ended is the strongest testimony to the success of CPHC in building community. As of June 2004, in each of the collaborative communities, a group of individuals continued to address the needs of children and families. When interviewed, almost half of the coordinators said that CPHC had changed the ways members engaged in community life because the initiative had shown them that their voices mattered and that they had assets that could be put to good use.

In addition to creating and sustaining collaboratives, in many cases community building also brought about other outcomes related to building social capital: increased social connections, increased social support, increased belief in an individual's power to bring about change, increased volunteerism, increased sense of the community as having assets, increased sense of civic pride and increased tolerance.

At the end of the initiative, as they had throughout the initiative, the collaboratives varied in size, focus, extent of resources, extent of connection with agencies and other

dimensions. But all were committed to the idea that individuals working together can bring about change, and were devoting time and energy to that end.

✓ ***All of the Phase IV community collaboratives, as well as some of the earlier grantees, were still active after the end of the initiative.***

One of the key hallmarks of sustainability is a collaborative's ability to sustain its community mobilizing and organizing efforts, as well as its programs and services. CPHC collaboratives in Phase IV became very attractive to other public and private funders. Resources for programs were far easier to secure than funding for core collaborative operating support. Although essential to continued community improvement, obtaining financial support for the core community organizing activities proved to be a challenge for many collaboratives.

✓ ***The CPHC Leadership Council was created and began coping with the organizational issues that are common to any start-up group.***

By the end of the initiative, the CPHC Leadership Council, with representatives from each of the community collaboratives, had formed and identified a vision and mission statement: "The CPHC Council supports grassroots, community-based collaboratives in their growth as effective agents of change to improve children's health in their communities and beyond."

The Council agreed to pursue this mission by providing training and technical assistance to collaboratives and communities in northern California, as well as networking support for collaborative and community leadership. The Council also agreed to work toward influencing policies at the local, regional, state and national levels, and toward spreading the community building approach to improving health outcomes.

By the CPHC initiative's end, the CPHC Council was continuing to work on internal issues related to structure and making significant strides toward carrying the CPHC initiative forward.

Phase IV Participation

Collaboratives were assessed and coached through three options: withdraw before the final phase, receive technical assistance and training only, or be fully funded to expand their impact and begin to develop and implement policy change strategies.

Eight withdrew; three participated in training and technical assistance only; and 15 received full funding.

Grants of up to \$100,000 were awarded for the final phase.

The CPHC Leadership Council was formed in November 1999 with representatives from 21 CPHC collaboratives to affect policy and continue the impact of the initiative.

Flashback: Cottonwood

The Cottonwood Partnership Action Council has never been part of CPHC – but its tactics and its most significant accomplishment can be traced directly to the initiative.

The tale begins with Shingletown, a small community in Shasta County that created the Grassroots for Kids collaborative as part of the CPHC initiative. In addition to creating a variety of community-strengthening projects, Grassroots embraced every training opportunity that CPHC provided. Since much of this assistance was in a “train-the-trainer” mode, Grassroots was equipped to share what it had learned with other communities.

The demand became so great that Grassroots spun off a nonprofit organization, True North, dedicated to serving as a formal resource in northern California for community development and leadership training. Grassroots saw the organization not only as a way to share knowledge but also as a powerful tool for policy change in rural areas.

Enter Cottonwood, a tiny town of 12,500 people spread over 40 square miles with few facilities for children and little influence with county policy makers. That began to change when Cottonwood activists discovered True North and began using some of its techniques.

The result: a \$110,000 grant from the Shasta Children and Families First (Proposition 10) Commission to fund Cottonwood Cares for Kids and a community playground facility. Today, Cottonwood Partnership Action Council continues to have an active role in promoting residents' interests.

Tips for Activists and Funders

The shift from community activities to policy work is challenging but critical to the long-term success and impact of collaborative efforts.

Policy work requires a different set of skills, and therefore training, than program implementation.

Collaboratives need leeway to find the proper balance between policy work and programs that will make their efforts effective on the broadest scale possible while keeping their membership engaged with the often-more-satisfying local activities and tangible successes.

Lessons Learned

Investing in building capacity of residents – in mobilizing the community, planning, program implementation, evaluation and advocacy– can have lasting impact on a community.

A community collaborative with a successful track record can attract resources to sustain its efforts.

Sustainability, however, is about more than just raising money for the collaborative. Programs can be sustained when they are “spun off” to other entities that take over the programs. Secure ongoing public funding for an effort is another. And having a group of trained, committed residents willing to address issues as they emerge in a community is still another.

Neighborhood collaboratives find it difficult to shift from expanding local program and services to policy and advocacy. Linking community residents to established advocacy groups can strengthen both bodies.

The Outcome

Did it work? Was a 10-year commitment and \$17 million enough to make a difference in the health of children in more than two dozen northern California communities?

The answer is not a simple yes or no. The evidence suggests that CPHC improved the health of some children in some communities with regard to some outcomes. There is also evidence that communities were strengthened in many ways. Communities are unquestionably better places when residents talk to one another, care about one another and give of themselves to make change happen.

Although precise measurement of all outcomes was not possible for a variety of reasons documented in the CPHC formal evaluation report, there are conclusions that can be drawn with a high level of credibility. Among them are:

Community building appears to be well suited for devising and implementing effective strategies to address straightforward health issues. Examples of CPHC successes are immunization clinics, dental screenings, fluoride treatments, recreation programs, parent support groups, community cleanups, health fairs and community gatherings.

Community building in CPHC was not as successful in addressing more complex health problems, such as drug abuse, child abuse, domestic violence and school readiness. As implemented in CPHC, with the level of support available, it may be unrealistic to expect that a small group of community residents could implement a variety of programs and policy changes that effectively would target the entire population at risk.

CPHC activities tended to impact small numbers of children through specific programs and services. Reaching a broader group required policy changes that were primarily undertaken in the final two years of the initiative. The problem with policy change, however, is that it typically takes a long time for even the most sweeping reform to improve health. As lengthy as CPHC was, it simply was not long enough to produce change that would impact health at a population level.

CPHC leaves a legacy that will continue to impact communities. At the end of the initiative, the 15 remaining funded collaboratives had secured resources to continue. The CPHC Leadership Council is in place and creating and pursuing a policy agenda to promote children's health. The Training Associates Project, an outgrowth of the CPHC commitment to training, had built the skills of collaborative members, who continued to train others in community development. The Dyson Foundation leveraged CPHC, funding a program at University of California at Davis Medical School to train pediatric residents in community building and advocacy. And many collaborative members were shaping the work of the First 5 (formerly Proposition 10) Commissions in their respective counties.

The CPHC initiative demonstrated that community members can come together, identify needs and resources, and mobilize these resources to positively effect community change. The goal of ultimately improving population health through community building proved more difficult to achieve.

The Goals

- ✓ ***To assist the communities in the region to identify needs of children and families and pursue new opportunities to address these needs.***

The evidence is strong that communities did identify and respond to needs. Collaboratives existed as ongoing bodies to identify and address the needs of children, and that is exactly what they did throughout the span of the initiative and after. By the end of the initiative, collaboratives had accumulated an extensive history of finding and pursuing new opportunities to meet the needs they had identified.

- ✓ ***To develop and strengthen the organizations and systems that respond to the needs of children and families.***

All available information indicates that both informal and formal organizations and systems changed because of CPHC. Associations, parent groups and other community groups were established and sustained. Even the more formal community organizations, like health and social services departments, began engaging community residents differently. But broader, systems change proved more than what grassroots community collaboratives could achieve during the grant period.

- ✓ ***To develop solutions to the needs of children and families by maximizing the use of existing financial resources and services through increased efficiencies and/or the reallocation of some resources and, where necessary, by developing new resources.***

Most collaboratives proved successful at mobilizing resources. The 15 funded collaboratives at the end of the initiative reported that they had attracted \$32 million in new resources over the course of the initiative and that sources of support continue to grow. Most of the collaboratives had access to few resources initially but over time they were able to pull fiscal and human resources from a variety of sources and combine them to improve their communities, such as by creating recreation programs or family resource centers.

- ✓ ***To achieve a lasting, positive impact on the ability of communities to respond to and organize around children's needs.***

CPHC accomplished this in three ways. First, the collaboratives themselves have been responding to and organizing around children's needs for more than a decade, and many will continue to do so into the foreseeable future. Second, the capacity that was built also remains as an ongoing force. Even if a collaborative is not able to continue, the individual and collective capacities of those who participated now exist in the community – both leadership and technical skills that can be put to use even without the collaborative structure. And finally, a voice has been given to residents. Even without a collaborative

structure, community members will retain the sense that their community has assets and that their input is needed and valuable.

✓ ***To improve the health and well-being of children and their families in the Sierra Health Foundation region (inland northern California.)***

This is the most complicated and far-reaching goal. The most appropriate summary is the one stated at the beginning of this section: CPHC improved the health of some children in some communities with regard to some outcomes. Overall the health of children was not improved at the population level. Important considerations to take into account are 1) the complexity of the outcomes collaboratives worked on, 2) the fact that service-based outcomes, such as providing dental screenings, were easier to impact than complex population health issues like child abuse, 3) the limited number of children who received a given service, and 4) the length of time it takes to improve health through policy change.

Flashback: Camptonville

The Camptonville collaborative in Yuba County has worked extensively to build a sense of community, creating events and information resources. Although none of the activities are child specific, the collaborative has been guided by the belief that strengthening the community has a positive impact on the lives of children.

But the collaborative also needed to measure the impact if possible. One outcome they identified was “children feel bonded and connected to an extended circle of caring adults.” To see if they were making a difference in this outcome, they went directly to the “experts” – the children themselves.

To keep adults and their perceptions from influencing the measurement, the collaborative had older students conduct a survey of children they were assigned to mentor. They asked the younger children to think of all the adults they knew with whom they felt safe, or felt comfortable asking a question, or would want to share an accomplishment with.

In 1999, children answering the survey on average could think of only two adults they felt connected to. By 2002, the number had increased to 12 adults. The trend is a positive one that demonstrates the impact of bringing residents closer together through community activities.

Examples of Specific Health Outcomes

In Plumas County, the number of reported child abuse cases dropped from 625 in 1995 to 325 in 2001.

In the Tahoe/Colonial neighborhood of Sacramento, 48 children received a dental screening in 1998; 329 were screened in 2001.

The West Modesto/King-Kennedy Collaborative reported the number of children participating in the collaborative-sponsored after-school recreation program increased from 66 children in 1998-99 to 111 children in 2000-01.

The Grassroots for Kids Collaborative in Shasta County reported an increase in the number of parents participating in children's sports leagues; 43 adults volunteered in 1997 and 78 volunteered in 2001.

In the Flats neighborhood in Sacramento, 40% of pregnant women received late or no prenatal care in 1994. By 1999, the figure was 24%.

Tips for Funders

Funders who choose to support community building through collaboration will need to acknowledge and be comfortable with the length of time it takes to have an impact.

The relatively small size of the CPHC grants made carrying out the work difficult, but it was an aid to sustainability in that collaboratives did not need to acquire much in the way of new resources to continue.

Funders need to direct resources to improve the quality of data available on the status of the health and well-being of children so communities can better evaluate their impact.

Encouraging community groups to track child health outcomes makes sense only if they have access to good outcomes data or are given enough resources to collect the data on their own.

Flashback: Tahoe-Truckee

When Children's Collaborative of Tahoe-Truckee settled on school readiness as a priority, it would have been easy to presume that helping pre-schoolers with their ABCs or their counting skills would be the answer. But the collaborative didn't just guess – they measured, using a standardized, nationally normed test to help them determine the most effective strategy.

What they found out was that the children in their community tested average or above average in overall results. Only when they teased out the finer points of the data did they see that 60 percent were below norm on gross motor skills. The long, snowed-in winters with few recreational opportunities for many low-income children were taking a toll.

The solution was KidZone, an indoor recreational facility that became a regional priority and opened in 2002. Although it is not possible to link specific children's test results with use of the facility, the collaborative has seen an increase in gross motor skills over time.

Flashback: Tuolumne County

Drug use was never acceptable in Tuolumne County but before the YES Partnership began its work, it was an issue that bubbled beneath the surface and was seldom discussed.

Today, after more than a decade of involvement in the CPHC initiative, the positive community norm that has been established is intolerant of drug abuse and the problems it brings. That doesn't mean that drugs have been eliminated, or even that domestic violence and child abuse related to drug addiction have subsided. But there is more community awareness of the issues and a communal commitment to addressing them.

"We have changed the norm about the use of substances and how they affect our youth and children," says Judy Halling, co-coordinator of the collaborative. "Complete prevention is impossible, especially because of our high rate of transiency in the county. But we believe the problems would have been much worse today if the YES Partnership had not been educating people and raising the visibility of this issue."

Conclusion

Was the CPHC experiment successful? The legacy of CPHC in northern California stands as strong testimony to the power of the concept.

The 10 years of the CPHC initiative saw many positive changes in the participating communities. Collaboratives were established or strengthened. Collaborative members came to understand and embrace the principles of community building. They identified issues and designed and undertook a variety of strategies related to these issues and other issues that emerged along the way. They saw their communities as places with assets and sought to use these resources in new ways to improve the lives of children and families. Many collaborative members are still working to make their communities better places even after Sierra Health Foundation's CPHC funding has ended.

CPHC has also shown that much of the work being done through collaboratives is not linear, in the sense that Action A will produce Outcome B. A variety of factors impact the health of children. Although this is widely acknowledged, there is much that is not understood about how the many factors interact to impact children's health – and, therefore, not much is clearly known about what can be done to line up all the factors perfectly to achieve good health outcomes.

From the evaluation of CPHC, it would appear that community building is an approach that is better suited to certain types of health strategies, especially ones where residents can organize and serve as providers (including recreation, safety, parks, etc.). It is also clear that community building is not a fast solution, but one that requires time (although more resources dedicated to support may drive progress more quickly).

At a minimum, CPHC has demonstrated that community building can make communities better places to live. Given the right circumstances, it appears that community building can also improve some health outcomes. CPHC has shown that using community building as a health improvement strategy is a slow but potentially powerful process. Harnessing that power effectively will take further work and investment.

TOOLS & RESOURCES

Asset-Based Community Development Institute at the Institute for Policy Research, Northwestern University – www.northwestern.edu/ipr/abcd.html

Annie E. Casey Foundation Initiatives: Improving Major Systems Serving Disadvantaged Children and Families, and Transforming Neighborhoods – www.aecf.org

Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine – <http://www.cacsh.org>

The Center for Civic Partnerships' California Healthy Cities and Communities Network – www.civicpartnerships.org

The Center for Healthier Children, Families and Communities – www.ph.ucla.edu/chcfc

The Colorado Trust's Colorado Healthy Communities Initiative reports – www.coloradotrust.org

Community-Campus Partnerships for Health – <http://depts.washington.edu/ccph>

Community Focus: Bringing People Together to Create Solutions, A Project of the Tides Foundation – www.communityfocus.org/core.html

Community Toolbox, Work Group on Health Promotion and Community Development, University of Kansas – <http://ctb.ku.edu>

An Evaluation Framework for Community Health Programs. The Center for the Advancement of Community Based Public Health – www.cdc.gov/eval/evalcbph.pdf

The Greenlining Institute – www.greenlining.org

Group Health Community Foundation: community programs and health evaluation services – www.ghcfoundation.org

National Community Building Network – www.ncbn.org

Neighborhood Funders Group – www.nfg.org

Partnership for the Public's Health – www.partnershipph.org

Promoting Health at the Community Level by Doug Easterling, Kaia Gallagher, and Dora Lodwick – www.sagepub.com

SRI International's Community Partnerships for Healthy Children evaluation reports – www.sri.com/policy/cehs/community/cphc.html

We Did It Ourselves: Guidelines for Successful Community Collaboration, developed by Sierra Health Foundation, Center for Collaborative Planning, and SRI International. Available by email: info@sierrahealth.org or www.cphconline.org/tools/guide.html

*A 10-Year Investment in Community Building to Improve Children's Health:
Evaluation of the Community Partnerships for Healthy Children Initiative*

W.K. Kellogg Foundation Evaluation Handbook – www.wkkf.org/Knowledgebase/Pubs