ABSTRACT
        This manual is a how-to-do-it guide to building coalitions
of health and human service agencies, organizations, businesses, churches,
and other community-based groups for collaborative research, planning, and
action to improve resident health and quality of life. Most of the
information provided was discovered and developed during the 4-year life of
the Madison Community Health Project, a community-based health initiative in
Madison County, North Carolina, based on a model developed in South Africa in
the 1940s. The manual includes six sections: 1) the nature, creation, and
maintenance of coalitions; 2) tools for assessing community needs and
evaluating program effectiveness (research methods, including surveys,
interviews, and focus groups); 3) tools for building consensus and effective
decision making, two panel discussions about local culture, power structures
and promoting community empowerment while including the powerful, and
facilitating and managing meetings; 4) guidelines for talking to potential
funding sources; 5) a case study of the Madison Community Health Project; and
6) a bibliography containing 97 references. Appendices include a sample
membership survey; a list of 78 grantmaking foundations with areas of
interest, geographical and other restrictions, average award, and contact
information; additional sources of funding information; and 17 2-page
coalition-building tip sheets. (TD)

Building A Healthier Tomorrow

A Manual for Rural Coalition Building

Suzanne Landis **Thomas Plaut**

June Trevor **Judy Futch**

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BUILDING A HEALTHIER TOMORROW

▼

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INTRODUCTION

This manual is a guide to building coalitions of health and human service agencies, organizations, businesses, churches, and other community-based groups for collaborative research, planning, and action to improve resident health and quality of life. The manual includes six sections:

- The nature, creation, and maintenance of coalitions
- Tools for assessing community needs and evaluating program effectiveness
- Tools for building consensus and effective decision making
- Guidelines for talking to potential funding sources
- Case Study: The Madison Community Health Project (1989-93)
- A bibliography for coalition building

Most of the information provided was discovered and developed during the four-year life of the Madison Community Health Project. Madison County is a mountainous Appalachian area on the North Carolina-Tennessee border. Although the W.K. Kellogg Foundation-funded health project ended in the summer of 1993, the Madison Community Health Consortium (MCHC) continues to function writing grant proposals, fielding projects, and serving as a community advocate for health-related issues. It was one of the first groups in the state to be accredited as a *Healthy Carolinians 2000 Task Force* and is a certified Governor's Task Force on Physical Fitness. The MCHC sponsors annual health fairs, physical fitness activities, and an anti-drug program. As of December 1994, it boasted more than 60 members.

The case study on page 26 provides the history of the project and the coalition. The bibliography on page 64 cites selected references that we have found helpful. Please note that the manual and the resources have been developed in relation to communities in western North Carolina. Rather than generalize references and resources to cover a broader geographic area, we felt that local specificity would be most useful to readers in other regions and states. In other words, we expect you will know or can find comparable agencies to the ones we cite in our region.

Our hope is that this manual can be a cookbook of sorts for rural communities. If you have questions or comments, please contact us.

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Forming and Maintaining Community Coalitions

Communities have many needs that can best be addressed through the collaborative efforts of public and private agencies, businesses, churches, voluntary associations, and individual citizens. Coalitions are an effective means for bringing these diverse elements together to envision, plan, and take action to improve health and overall quality of life.

What is a coalition?

A coalition is "an organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently." (Brown, 1984). Coalitions can be grassroots, professional, or community-based. (Feighery and Rogers, 1990). They can exist for one or more of these goals: networking, coordination, cooperation, or collaboration. (Wolff, 1993). *Consortium, partnership,* and *community task force* are terms used interchangeably with *coalition.* Some coalitions have a political mission, but the term also embraces partnerships committed to improving health and quality of life in a community. (Feighery and Ross, 1990). "Coalitions formed for promoting health are a long-term investment for a community and focus on multiple activities." (Butterfoss, Goodman, and Wandersman, 1993, 318).

A coalition is best defined by the community that creates it. We consider community coalitions to be products of community energy and action based on community definitions of the world and reality around them.

All coalitions start with a common interest or concern. While there is no prescribed sequence in which coalition development events should occur, all coalitions must at some point undertake the following steps in order to function effectively. Coalition members should **collectively**:

1. Invite representatives from health and human service agencies and community organizations to discuss a common vision for the future.
2. Arrange for the management of meetings.
3. Establish membership policies.
4. Determine how decisions will be made.
5. Conduct a needs assessment and prioritize the needs identified.
6. Define the coalition's mission, goals, and objectives — based on shared vision and prioritized needs.
7. Develop an organizational structure to best respond to prioritized needs.
8. Develop and implement action plans.
9. Evaluate outcomes of the action plans that are implemented and evaluate the coalition itself.
10. Celebrate successes and look to membership for problem-solving when action plans or coalition development are not effective.

Some common questions about coalitions are discussed in the next chapter.

COPC: An effective method for coalition building

Coalition building needs to be solidly based in the community and the lives and world views of its residents. The Madison Community Health Project (MCHP) found that the best method for developing a sound framework for coalition building was the Community Oriented Primary Care (COPC) model. COPC was developed by two physicians, Sidney and Emily Kark, while working among the Zulu in South Africa in the 1940s. The Karks defined a four stage process:

1) *Identifying the community* as a geographic area and its population. Note that this is not a definition of clients of a particular agency or health facility; it is the entire population of an area. Once the geographic area and its people are determined, there is additional study of social structure and economy, formal and informal social networks, and values and behaviors that relate to health and health care. This includes exploring any traditional healing or "folk" remedies. In Madison County, we found that the residents' definition of "community" was particularly salient in designing community action programs.

2) *Identifying community health problems* and issues by gathering two kinds of data. *Quantitative data* provides morbidity and mortality (including "years of life lost") rates, per capita income, poverty levels, percent of substandard housing, and other demographic, social, and quality of life data. *Qualitative data*, gathered through group and individual interviews, gives important insights into community values, attitudes, and perceptions of health and health care, and how people solve problems in everyday life.

3) *Involving the community* in determining priorities in health needs and designing and implementing consequent health interventions.

4) *Ongoing evaluation* of projects to monitor their effectiveness and enable ongoing refinement of efforts. (Kark 1981; Nutting 1990; Trostle 1986).

The Madison Community Health Project began by documenting local residents' definitions of "their community," and making a map of the county based on these definitions. *(See map on page 33.)* Project staff then held 40 focus groups to obtain residents' understanding of health care problems and barriers to health care. We also collated and examined existing census data and health statistics on the county (i.e. examination of secondary data). The results were presented to a project Community Advisory Board (CAB), which prioritized needs and determined actions to be taken. All program activities included evaluation methods. A more complete description of the Madison Community Health Project's use of the COPC process can be found in the Case Study on page 26.

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Coalition building tasks

1. **Invite representatives from health and human service agencies and community organizations to discuss a common vision for the future.**
   Even in the start-up stages, the core planning group should represent the broader community. It is important that representation include public health and human service agencies, hospitals, private nonprofit services, the business community, churches, civic clubs, and disadvantaged populations if possible. Membership can expand as the coalition implements its action plans, but member recruitment and community ownership will be strengthened by starting up with a broad-based core planning group.

   The Madison Community Health Consortium's early membership tended to have more professional and agency people than lay representation. However, the focus group data that fed the needs assessment and intervention process ensured lay citizen input. The focus group process also established a network with the respondent groups, such as community development clubs and volunteer fire departments, that has continued to grow in the course of consortium action projects. We have found that involvement in the focus groups and action projects turned out to be a meaningful way for many lay citizens who were not comfortable with meetings or unable to attend them to be involved. (We consequently wonder about requirements in some government-funded initiatives that X percent of a planning board be made up of "disadvantaged" or minority people. We have been able to engage a broad spectrum of people in the consortium, but in ways that were familiar and comfortable for them.) *(See Community Assessment and Project Evaluation on page 14 for more on focus groups.)*

   Coalition building preferably begins with a shared vision of the future and not an emphasis on the many problems in the community. A vision is a collective image of the ideal community in the eyes of coalition members. There are group "visioning" exercises, best conducted by trained facilitators, that help coalition members develop and document their vision. Creating a future vision helps the coalition plan proactively rather than reactively.

   The Madison Community Health Consortium did not create a formal "shared" vision in its start-up phase. Original interventions, while preventive in nature, were based on identified *barriers* to good health. Members later participated in a nominal group process of vision development, conducted by a facilitator experienced in this exercise. This vision of a healthy Madison County serves to guide current action planning.

2. **Arrange for the management of meetings.**
   Coalitions just starting may want to recruit a trained facilitator to manage the first several meetings, particularly to help with establishing a shared vision. Feighery and Rogers (1990) recommend that new coalitions delay electing a chair, appointing an interim facilitator for the first several meetings. This allows time for the members to determine who among the membership has the most appropriate leadership skills.

   The facilitator role is important to the coalition decision-making process. *(See Facilitating and Managing Meetings on page 49.)* The facilitator should be able to "set agendas and conduct meetings efficiently, while fostering communication and a clear sense of the coalition's direction." (Feighery and Rogers, 1990, 6).

In an evaluation of the Madison Community Health Consortium in 1991, members reported that "neutral facilitation" was a factor for consortium effectiveness. Project staff, who were not agents of any member organization, functioned as neutral facilitators for several years. Currently, teams of volunteers from the general membership rotate the facilitation of meetings. These volunteers have been carefully trained to maintain their neutrality in group decision-making.

3. **Establish membership policies. (For example, should membership be inclusive or exclusive?)**

Coalitions should "make initial membership decisions that would create a sense of equal access to the coalition." (Community Partners.) To deliberately exclude some individuals or factions within the community could mean losing access to a valuable resource for community action. Feighery and Rogers (1990) advocate the "snowball" method of recruitment, by which key organization representatives are asked to refer others who would contribute to the work of the coalition.

The MCHC has an *inclusive* membership. The consortium considers membership to be open to anyone living or working in Madison County, who agrees with its mission statement, and is committed to work toward that mission. Some have joined due to interest in specific projects. Members annually renew their commitment to the mission statement and designate their desired level of involvement.

Designating *levels* of participation for members is helpful. Members who can rarely attend meetings still value receiving minutes and contributing to special projects. (Shaler, 1991). MCHC members commit to their desired level of involvement when they renew their membership annually. Members can serve as Meeting Participants (attending plenary meetings and/or meetings of subcommittees). Members unable to attend meetings have the option to serve as Resource Persons, available to disseminate information, contribute their expertise when needed, or help with one-time projects such as health fairs. *(See Appendix for sample Membership Survey.)*

4. **Determine how decisions will be made.**

It is important that all members be in agreement on how coalition decisions will be made, whether through formal voting procedures with quorums or consensus building. The Madison Community Health Consortium did not develop a formal policy on decision-making. As decisions were made, the members were consulted about the best way to reach a decision (deciding on how to decide). As a result, a tradition evolved of making decisions by consensus.

Our "open door" membership policy includes the understanding that anyone who comes to a meeting may vote. Difficult decisions may require more than one meeting to resolve. Decisions are never rushed. We have found that an atmosphere of informality is important. Sometimes the coalition agrees to indicate support by a show of hands, sometimes by nodding (or shaking heads). Much of the consensus-building among members takes place in "task force" committee meetings that result in recommendations to the full consortium.

5. **Conduct a needs assessment and prioritize the needs identified.**

Coalition building begins with listening, learning how community residents define:

- community strengths and needs
- barriers to good health
- possible solutions

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Needs assessment must include qualitative data regarding community members' perceptions about problems and solutions, along with quantitative data. *(See Community Assessment and Project Evaluation on page 14.)* Both types of data were helpful to the Madison Community Health Consortium in understanding local health problems.

Small group discussions are an effective means for the coalition members to have maximum input in reviewing and prioritizing needs. The consortium used a nominal group process to prioritize the health problems that should be addressed in Madison County. *(See page 52 for more on nominal groups.)*

6. **Define the coalition's mission, goals, and objectives — based on shared vision and prioritized needs.**
A mission statement is different than a vision. It is a general statement of the coalition's purpose. A mission translates the coalition members' common beliefs and values into a statement of action. It identifies what they believe, who they serve, what they will do.

Every coalition member should contribute to the process of developing the mission statement, as well as goals and objectives. (Feighery and Rogers, 1990). Goals are measurable statements of the projected long-term outcomes of the coalition's actions. Objectives are specific measurable statements of short-term outcomes to be achieved. Members of the consortium were involved in drafting a mission statement and overall goals. The Resource Committee (long-range planning) further refined the mission statement and goals, and presented them back to the full consortium for editing and approval.

7. **Develop an organizational structure to best respond to prioritized needs.**
Goals, objectives, and consequent actions will serve as a basis for determining the most appropriate organizational structure (what types of committees should be created, whether a steering committee is needed, etc.). Organizational structure can be formal or informal. "The precise model selected by the coalition should...reflect the needs of the community and the makeup of the coalition, as well as the objectives of the coalition." (Feighery and Rogers, 1990, 6). Mogul (1990) recommends flexibility in the structure to allow for organizational change to occur as coalition goals change.

Form follows function. The Madison Community Health Consortium has opted for a loose flexible structure without a centralized authoritative group, such as a steering committee. Members are invited to volunteer for specific task forces, or committees, to accomplish the specific planning and implementation associated with various projects that the consortium has proposed. Committees have evolved over time as priorities and projects change. Currently, four MCHC committees address specific projects. These include the Substance Abuse Task Force, the Fitness Council, the Senior Health Fair, and Injury Prevention/911 committees. A fifth committee, the Resource Committee, serves as the long-term planning body; it also looks for sources to fund consortium projects.

8. **Develop and implement action plans.**
An action plan is a written plan that incorporates the coalition's proposed objectives and planned actions for addressing a particular health issue. There are many formats for writing action plans. A simple action plan format is shown on page 58. A more complex action plan format can include columns for documentation of proposed tasks, who will complete them, deadlines for completion, barriers to task completion, supplies or resources needed, and the date the task was accomplished. (Southeast Regional Center for Drug Free Schools and Communities, 1994.) The plan guides implementation and

enables organizations to decide and propose how they will contribute to and collaborate in a project. In the MCHC 911 program, for example, volunteer firemen provided space for community health education in their fire halls; schools provided class time to teach children how to use the 911 emergency system and local medical centers distributed 5,000 flyers to patients.

9. **Evaluate outcomes of the action plans that are implemented and evaluate the coalition itself.**

It is important to regularly evaluate the coalition, as well as its projects, in order to refine and develop operations. *(See Community Assessment and Project Evaluation on page 14.)* Francisco and Wolff, 1994, recommend three evaluation components:

- *Process* evaluation of day-to-day operations, board member and client satisfaction, funding generated, development of leadership and structure in the coalition, media coverage and assessment of critical events in a coalition's history.

- *Outcomes* evaluation focuses on a consortium's products: number of people immunized, number of newspaper articles written and published, number of public events, programs for teens, or development of new services in the community.

- *Impact* evaluation using statistical indicators of reduction in rates of behaviors (smoking or driving without a seatbelt), or morbidity or mortality rates. Obviously, impacts take longer to materialize in data than outcomes.

An evaluation of the MCHC, focused on process and outcomes, was conducted in 1991 by an independent evaluator and was replicated in 1993 by project staff. An anonymous questionnaire was sent to all members who rated meeting organization, member participation, projects implemented, member satisfaction with the overall consortium and its projects, and strengths and weaknesses of the MCHC. We are collecting county-wide morbidity and mortality statistics to assess the impact of our interventions.

10. **Celebrate successes and look to membership for problem-solving when action plans are not effective.**

Coalitions need nurturing and renewal. Successes need to be celebrated and members' contributions recognized. Taking time for ceremonies is important. The MCHC has a "birthday" party every summer, with cake and candles, to celebrate its longevity. Special meetings or press conferences have been called, with all members invited, to announce grants awarded. The Healthy Carolinians plaque was given to the director of Asheville-Buncombe Technical Community College's Madison Campus to hang in the building where the MCHC meets and where the whole community can see it.

When projects don't reach intended goals, turn to the membership for insights and solutions. MCHC members, rather than being dissatisfied, have been wise advisors at such times: "Next time, let's try it this way...."

The lessons we learned were *continue to listen to the community* and *monitor project impact.*

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Common Questions About Forming and Sustaining Coalitions

■ Isn't coalition building just another name for community organizing?

NO! Coalition building is *networking*. *Organizing* assumes that the community is disorganized, or deficient in organizing itself, whereas networking:

- assumes community residents are already organized by family, neighborhood, churches, clubs, volunteer fire departments, and other community organizations.

- seeks to link existing organizations and agencies together for collaborative, community-wide planning and action.

- focuses on mobilizing groups rather than individuals.

■ Why create a community coalition, especially if your community already has ample resources?

Incentives for coalition building are both internal and external. External forces mandate coalition development in many cases. Obvious incentives for forming coalitions are the advantages for receiving grants that require a collaborative focus, such as North Carolina's *Smart Start* initiative for children, which requires a community coalition to apply for funds and operate the program. The state-level Healthy Carolinians program encourages and assists communities to form task forces to select and accomplish year 2000 health objectives.

Prominent internal motivations for creating coalitions are to:

- better understand the needs in a community through involving professionals and citizens in needs assessment and identifying solutions.

- consolidate various agencies' needs assessment results into a more comprehensive central database.

- reduce duplication in services.

- enable better information exchange and coordination among a growing array of community resources.

Regardless of the external forces mandating coalitions, the motivation to form a broad-based coalition must come from the community itself in order for community ownership to be established. Coalitions are believed to be a means of strengthening community capacity to solve problems. (Butterfoss et al, 1993).

■ What skills are needed to develop a coalition?

The following skills are recommended and were represented in the MCHP by a team of project staff and volunteers from the membership:

- Community and group facilitation skills.

- A community development orientation.

- Knowledge of the community.

- Awareness of cultural traditions and community power structures. *(See Rural Culture and Coalition Building on page 34, and Coalitions and the Existing Power Structure on page 42.)*

- Organizational skills to maintain minutes, membership lists, correspondence, surveys, etc.

- Knowledge of the Community Oriented Primary Care (COPC) method. As stated in the last chapter, this method enhanced coalition formation under the Madison Community Health Project.

Is staffing essential?

Some limited staffing is helpful for managing coalition activities, particularly in the early stages for group facilitation and such tedious tasks as meeting announcements and arrangements, mailings, and the recording, typing, and distribution of minutes. Wolff (1991, 26) found the value of part-time staffing of several Massachusetts coalitions. "The coalitions are intentionally understaffed settings, guaranteeing that any new programs developed must be spun off to other community organizations."

The Madison Community Health Consortium had funding for a paid part-time facilitator and assistant for six years. The staff members represented themselves as "secretaries to the community," emphasizing that the coalition had the authority for decision-making and action. Now, Consortium volunteers are trained in facilitation skills and two-person teams facilitate consortium meetings. To maintain neutrality, the teams never include two people from the same agency and volunteer facilitators step out of the facilitator role if a decision affects their agency. This system promotes leadership development and greater ownership of the consortium process among the membership and an increasing capacity to function without a paid facilitator.

■ How often should coalitions meet?

The coalition can decide how frequently it needs to meet to accomplish its goals and objectives. Feighery and Rogers (1990) recommend that meetings occur no more often than monthly. Butterfoss et al. (1993, 324) report that "durable coalitions often have frequent meetings that members are actively encouraged to attend."

The Madison Community Health Consortium meets every two months, with its subcommittees meeting monthly and reporting back at the plenary meetings. Plenary meetings, depending on the agenda, alternate between being work sessions, where nominal group techniques are used to maximize member input on an issue (e.g. prioritizing health objectives to address under Healthy Carolinians), and forums for information-sharing among subcommittees and member organizations.

■ How structured and how long should coalition meetings be?

The MCHC experience suggests that different kinds of time are needed — informal and formal. The formal meeting may be scheduled for two hours; however, an additional half-hour needs to be provided to enable participants to talk informally about items of concern.

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MCHC meetings have always started with an informal lunch, which enables communication and problem-solving and clears the air for the business meeting. Differences and concerns between members often are settled during the informal part of the gathering.

In our experience, meetings should emphasize process over rules. It's important that meetings be well organized but at the same time, group input and information-sharing must flow freely. Robert's Rules of Order do not lend themselves to our informal format. Small group techniques, such as nominal groups, allow for maximum input from participants in consensus building. *(See page 52 for more on nominal groups.)*

■ How do coalitions maintain a balance between planning and action?

Coalitions can have a fast start, only to fizzle out. Time invested in planning and consensus building pays off in bonding among members and coalition products. Florin, Mitchell, and Stevenson (1993, 431) claim that "the challenge is to balance our sense of urgency and need to act with the planning, support, and study necessary to sustain action." Short-term products help to keep members motivated and involved. In the MCHC, short-term actions, such as the publication of a Parents' Resources Guide, helped generate energy for the more complex long-term project of developing a lay advisor program for parents of newborns. Short-term, manageable projects help with team-building among coalition members, create a sense of accomplishment, and enhance the coalition's capacity to handle more difficult projects. (Butterfoss et al., 1993).

■ How do you sustain coalition membership?

Viewing the coalition as a forum of organizations *represented* by individuals helps in sustaining membership. When individuals change jobs or move away, a new representative is sent and the *organization's* continued involvement is ensured. Continually providing concrete roles for members to play in the coalition process and acknowledging their contributions help. Members will derive more satisfaction from being part of a *productive* coalition. One must also emphasize an "open door" policy for meetings, where *individuals* are welcome and can be "voting members" just by showing up.

■ Working with coalitions takes a lot of time and can be frustrating. Does it ever get easier?

The MCHC project staff had to do much of the "homework" between coalition meetings initially. Once a shared history of successes began to develop, members began to assume more leadership roles and take on more responsibility for performing specific tasks that were originally conducted by project staff.

Staff must be prepared for the gradual process of group development. People come to meetings with different agendas and definitions of community needs and problems. It takes time for common understandings and agendas to develop. Facilitators must feel comfortable in allowing this process to unfold over a period of months. The MCHC took almost a year to develop as a group, but once the sense of group identity was realized a number of projects were designed and moved into action. It takes months to plan and build a house; why shouldn't coalition building take even a little more time?

■ Some coalitions form because of a grant. How do you keep them going once the funding ends?

Wolff (1994) suggests that coalitions can sustain themselves if they are adaptive to changes in the community. Membership and leadership can rotate. An important factor in sustainability is the capacity to continually take action in the community.

To maintain itself after the W.K. Kellogg Foundation grant ended in August, 1993, the MCHC has adopted the strategy of institutionalizing its efforts, a strategy recommended by Wolff (1994). Projects originally funded with the Kellogg grant became part of local agencies:

- The flu/pneumonia vaccination program is now an ongoing program of the Madison County Health Department.

- The Senior Citizens Health Fair is sponsored by the local American Association of Retired Persons chapter with other consortium member collaboration.

- Part-time coalition staffing and office expenses have been paid for by the private, nonprofit Hot Springs Health Program, a comprehensive multisite primary health care system in Madison County.

■ Should coalitions incorporate?

Advantages of incorporating include coalition ability to receive funds, to sustain professional staff and interventions. (Wolff, 1994). However, bureaucracy within the coalition can be a barrier to maintaining community ownership and sets up a competitive relationship with member organizations.

Twice in its five-year history, the MCHC has debated incorporation and opted not to incorporate for several reasons. Members view the consortium as a neutral forum for identifying needs and solutions. As projects are funded, the consortium determines the appropriate member organization to serve as lead agency and receive the funds. Grants awarded to the Madison County Health Department, AARP, and the Hot Springs Health Program have paid for various collaborative consortium projects. This approach has strengthened member organizations' capacity for grant writing and program development.

■ What makes an effective coalition?

The following principles seem key to successful coalitions. (Foster and Wolff, 1993; MCHC):

- Mission statements and goals suggest a vision and how to achieve it.

- Inclusive membership opens the door to everyone. Community capacity to address health problems has been strengthened by linking professionals and lay volunteers in carrying out consortium projects.

- Allowing time for informal interactions (meeting over meals) enhances formal interactions.

- Organizational competence implies a structure for meetings and effective communication.

- Neutral facilitation enhances broader participation.

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- Action and advocacy accomplish projects that meet community needs.

- Hope and celebration acknowledge and reward coalition successes.

- Time and persistence mean working in small steps to achieve long-term goals.

- Monitoring and assessment are a vital part of improving coalition effectiveness. We recommend following the COPC process and involving focus groups in needs assessment. *(See Community Assessment and Project Evaluation on page 14.)*

Community Assessment and Project Evaluation

The cornerstone of coalition building is an assessment of the community, its leadership and networks, needs and strengths. Whatever group or activity develops is dependent upon the accuracy of the original assessment research. Assessment for coalition building should try to gather much of the data in the language and world views of community residents, involving them in a process of collaborative discovery that may open the door to collective action.

While this chapter provides an overview of various research methods, it pays special attention to focus groups as the best method for accessing the community understanding and opinion upon which a coalition's legitimacy and success ultimately rest. Once a coalition has assessed needs and implemented programs, evaluation is required to monitor efficiency and outcomes. Project evaluation is key for coalition planning and development, and is required by external funding sources, be they private foundations or public agencies. For assessment and evaluation:

1. Choose research methods according to the task at hand.

2. Begin your assessment with a literature search and review of agency data.

3. Gather community data, knowledge, and opinions — with surveys and interviews of individuals.

4. Use focus groups to explore community values and opinions. Issues in the design of focus groups include:

   ■ The number of groups needed to obtain the data.

   ■ Selection of focus group participants.

   ■ Numbers of participants in each group.

   ■ The time required for interviews.

   ■ Strategies for focus group question design.

   ■ Selection and training of moderators.

   ■ Techniques for conducting focus group interviews.

   ■ Enhancing validity and reliability of data.

   ■ Analysis of data.

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Community Assessment and Project Evaluation

1. Choose research methods according to the task at hand.

Efforts to build a coalition begin with an assessment of the target community, its strengths and needs, and how its residents (some of whom are or will be coalition members) define its strengths and needs. Assessment leads to action in the form of projects that require evaluation to determine levels of success. Many methods exist to assess community health and evaluate projects.

For **community assessment**, The Madison Community Health Project (MCHP) employed:

- *Individual interviews* with key informants to

    – map the area of study by resident definitions of community boundaries.

    – develop questions for focus groups.

- *Focus groups* to gain insight into community perceptions of

    – wellness and disease.

    – causes of illness and barriers to health care.

    – groups denied access to adequate care.

    – local "helpers" and leadership.

    – the target population's interpretation of quantitative data gathered in the community assessment process.

- *Statistical data* from government agencies for data on

    – morbidity and mortality.

    – employment and income levels and housing quality.

    – social pathology: crime rates, findings of neglect & abuse, etc.

For **project evaluation**, the MCHP used:

- *Surveys* of project Advisory Board members' opinions of the project and their roles in it. Members were surveyed two years into the project and again at the end of its four-year cycle. *(See page 17.)*

- *Individual interviews* for verification and deeper insights into survey results. They were also used to assess client feelings and opinions at the end of the parent support project. *(See page 18.)*

- *Quantitative measures* of specific outcomes, such as reduced cavities in school children treated with dental sealants and compliance with infant immunization schedules.

2. Begin your assessment with a literature search and review of agency data.

A good place to begin a community assessment is the library. A literature search will locate similar projects and their assessment methods (no need to "reinvent the wheel"). Libraries also have data from the U.S. Bureau of the Census which can provide basic information on the composition of the local population, income levels, quality of housing, etc. More detailed information broken down for local census tracts is often available from local planning agencies *(see below)*. Medical libraries have data from State and Federal agencies such as the Centers for Disease Control. Some data you will want to have, along with where to find them, include:

■ Mortality and morbidity rates

- Centers for Disease Control, Mailstop C-108, Atlanta GA 30333

- State Center for Health and Environmental Statistics (SHES), NC Department of Environment, Health and Natural Resources (or corresponding agency in your state), P.O. Box 29538, Raleigh NC 27626-0538. You can telephone the Education and Training Coordinator at (919) 733-4728.

- Local Health Departments in North Carolina biannually receive a "Guide for a Community Diagnosis: A Report for Local Health Departments" from the Department of Environment, Health and Natural Resources.

- AHEC (Area Health Education Centers) libraries
  For western North Carolina: Mountain Area Health Education Center, Information Services, 501 Biltmore Avenue, Asheville NC 28801, (704) 257-4400.

■ Demographic and economic data (age groups, income levels, housing quality, birth, marriage, divorce and death rates, levels of educational achievement)

- U.S. Bureau of the Census Population Survey data, Abstracts and City/County Databook are available in most public and university libraries.

- NC State Data Center. Office of State Management and Budget, 116 West Jones St., Raleigh NC 27603, (919) 733-7061.

- Regional planning councils. For North Carolina Region B: Land-Of-Sky Regional Council, 25 Heritage Drive, Asheville NC 28806.

Data on social problems, such as crime rates and reports and findings of abuse and neglect:

- Bureau of the Census

- U.S. Justice Department, Bureau of Justice Statistics, 633 Indiana Ave. NW, Washington DC 20531: Uniform Crime Reports (UCR); National Crime Survey (NCS)

- National Criminal Justice Reference Service, Box 6000, Rockville, MD 20850.

- Local and state law enforcement agencies.

- Local Departments of Social Services keep tallies of reports and findings of abuse and neglect and numbers of people applying for eligibility-based programs such as food stamps. You can divide the number of cases reported/found by your county population and then multiply by 1000 to come up with a rate to compare with other counties, municipalities, the state or nation.

3. Gather community data, knowledge, and opinions — with surveys and interviews of individual residents.

Conducting surveys. Although some of the community assessment data is available from agencies, much of it will need to be gathered locally. Data on local behaviors, attitudes, and opinions can be generated by surveys of samples of your target population. It takes skill and experience to design a good survey, so it is helpful to find someone who can provide assistance to your group in developing it. Some general rules are:

- Determine what you want to find out and how you will use the data. For example, results of a survey of patient work schedules can be used to make medical center hours more convenient. Results indicating that the elderly do not get pneumonia immunizations because of the lack of public transportation to the health department suggest that immunizations should be made available in neighborhood community centers.

- Be sure that the survey is the correct research tool. If you want to determine how many women got mammograms in the past year, you can ask a sample of women in a survey. If you want to know why some women don't get mammograms, you may need to collect your data from focus groups.

- Determine whom you will survey. Will they truly represent the attitudes and opinions of the target population? Will you conduct a random sample, calling every tenth name in the telephone book, or a convenience sample of people walking into a supermarket or medical center? If you want to "generalize" your findings to your entire population, you need to conduct a random sample.

- Ask only what you need to know; the fewer questions, the better — for the interviewers, data entry and analysis, and the interviewee. An even better rule of thumb is to keep the survey time to less than 20 minutes.

- Determine any "break characteristics" (Knodel, 1993) that distinguish important subgroups in your target population. For example, one useful characteristic might be gender, if you wanted to distinguish between the attitudes or behaviors of women and men. Some other possible break characteristics are ethnic or age groups, education levels, occupation, or neighborhood of residence.

- Code your questionnaire for easy data entry. For example, assume question #1 relates to gender and #2 to neighborhood. The interviewer should simply have to circle an item:

1. Gender	1) male
	2) female
2. Residence	1) Laurel community
	2) Spring Creek
	3) Suffering Achers
	4) Piney Meadows

If a respondent is a woman living in Piney Meadows, the data entry person types "2" at question #1 and "4" at #2. A well-designed questionnaire (which, when properly numbered for easy data entry, becomes a "codebook") saves time and money, while enhancing accuracy in data entry. A helpful reference is *Designing and Conducting Health Surveys*, by L.A. Aday. *(See Bibliography.)*

- Decide if the survey will be administered

  – in one-on-one, face-to-face interviews,

  – to groups of people, such as school children, writing answers on a question-naire,

  – via mailed questionnaires (the response rate is typically less than 40 percent), or by telephone interviews.

- Make certain your questions are clearly understandable and your syntax comfortable for your target population. "Are you sexually active?" appears to mean to you, the questioner, "Do you have sex?" But when one of the authors asked this during an interview, a respondent replied, "No, I just lie there."

- Pre-test your survey instrument. It should work two ways: the respondents need to understand clearly what you're asking and, secondly, you need to get the answers that meet your data needs.

Individual interviews, especially with "key informants," can be helpful in discussing the feasibility of possible projects, insights into local power structures and leadership patterns, and preliminary insights into community strengths and problems. Although the interviewers should be well prepared and have a clear sense of the information they are after, the structure of the interview can be much more "open ended" than is possible when administering a survey. Responses can be written up after the interview on a question-by-question basis and followed by a summary. Sometimes it is useful to use the anthropologist's "field notes" idea to record descriptions of the setting and circumstances of the interview, together with impressions of the client demeanor and comfort, interviewer comfort, etc.

4. Use focus groups to explore community values and opinions.

Focus groups provide unique information about group perceptions and the definitions of reality that ultimately affect behavior. We dwell on focus group methods at length because we found the data they generated on community perceptions of health and health care delivery systems were particularly helpful in designing our action projects. We have also found that they are not well understood as a research tool and so we offer the following explication.

- *Focus groups are uniquely appropriate for sensitive situations.*

  – Focus groups were employed in the MCHP only after a community member serving on the project's Board of Directors objected to a survey, arguing "these people have been surveyed to death....They're tired of being asked how poor they are."

  – Focus groups reach people who will not respond to surveys for a variety of reasons: suspicion of research or of people they don't know, fear of disclosure, marginality, illiteracy, and intimidation. The MCHP encountered suspicion (and some hostility) especially among low income rural men for whom focus groups provided a safe and supportive place to express insights and feelings. Focus

groups give much of the control enjoyed by the interviewer in a one-on-one interview and to the group. (Crabtree, 1993). MCHP staff interviewed people in their community centers, schools, offices, and volunteer fire departments — on their own turf. The participants were on home ground and the moderators were their guests.

— Focus groups provide a sense of "safety in numbers" for subjects who would feel vulnerable and/or intimidated in a one-on-one encounter with a researcher. One MCHP focus group of farmers and small businessmen, who were also volunteer firefighters and emergency medical personnel, expressed a high level anger with local physicians; it is doubtful that any of the participants would have done so in one-on-one interviews, where they would have been concerned with the moderator's impression of them as individuals. The safety of the group provides greater space for the expression of feelings and also can overcome some of the distance between target group and researchers created by factors such as language, culture, and region. (Morgan and Krueger, 1993).

• **Focus groups are "a friendly research method** that is respectful and not condescending to your target audience." (Morgan and Krueger 1993, 18).

Several times we were asked "Will you come back? Can we do this again?" Participants found the groups meaningful and affirming. Because the MCHP focused on health needs and services, its focus groups provided participants an opportunity to discuss concerns encountered at work and in their own lives and community, such as loss of health insurance and income. Teachers, for example, were concerned about students who had large and visible cavities but had never been to a dentist.

• **Focus groups elicit**

— perceptions and world view shared by a group of people having similar characteristics or a common life in a community.

— responses to issues, policies, and goals.

— a broader range of response, detail, and insight than is accessible in individual interviews and surveys.

— emotions associated with perceptions and responses.

— data developed out of group interaction. (Crabtree 1993, 144).

— group understandings and definitions of situations and events. (To paraphrase Joseph Campbell, focus groups can elicit the collective "myths people live by.") For example, several of our focus groups defined some physicians in local health centers as "dirty...hippies hired right off the Appalachian Trail" and "the bottom of the barrel...if they were any good they wouldn't be here." These understandings were not found to be the case in fact, but they impact health-related behaviors, use of the medical centers, and willingness to "follow the doctor's orders."

— respondent interpretations of questions (for example, questions being considered for use in a survey).

— respondent interpretations of survey responses.

■ How many focus groups are needed?

Although four to six groups generally are recommended, your type of research and purpose should determine the number:

- For **project evaluation** — enough groups to cover the different kinds of people, stake-holders, or constituencies involved.

- For **comparative research** — at least six to eight groups are suggested. (Morgan 1988, Krueger and Morgan 1993, Crabtree 1993). Knodel uses "break characteristics" to define subgroups, such as rural v. urban and elderly and their adult children, in a target population to determine the number of groups required. At least one group is needed for each combination of break variables used to differentiate subgroups. In this case, the two break variables define four population subsets: 1) urban elderly; 2) rural elderly; 3) rural adult children; and 4) urban adult children. A minimum of four focus groups would be required. (Knodel, 1993, 39).

- For **action-linked research,** associated with efforts to network various agencies, organizations, or constituencies together (i.e. coalition building) — at least one focus group should be held for each constituency. The MCHP conducted 40 focus groups to get the widest possible input, while also promoting the discussion of health-related issues and networking for eventual community action.

■ Selecting focus group participants

A "textbook" approach selects people by random sample and then invites them to participate. Krueger (1993, 71-73) cautions against convenience samples (using the most available or easily accessible subjects), but convenience samples can be successfully employed, especially in working with sensitive topics and marginalized populations:

- O'Brien recruited subjects for a study of gay and bisexual men at risk for AIDS by attending meetings of 13 organizations and "soliciting the first names and telephone numbers of interested people; later we telephoned these individuals to arrange times for discussions." (O'Brien 1993, 107-108). Jarrett recruited participants at Head Start sites, to study the everyday life experience of low income African-American women. (Jarrett 1993, 187; 1991, 1992). Using informants' suggestions to build a list of potential participants is sometimes called "snowball sampling."

- MCHP staff converted meetings of 40 agencies and organizations into focus groups to capture respondents who might not have volunteered to participate in a group in less familiar and safe surroundings.

Morgan (1994) emphasizes that:

1. Group homogeneity is important — participants will talk more readily when they feel that they are with people like themselves, who will share similar experiences and thus understand what they say.

2. Groups can also be composed for comparisons. Probably the most common example of this kind of research design is comparing users and non-users of some service. An example from Morgan's (1994) work was a comparison of families who had sought diagnosis for an older family member with Alzheimer's Disease, where they compared families who had come in for diagnosis while symptoms were still relatively mild to those who sought diagnosis only when the symptoms were more severe.

3. Both the issues of maintaining homogeneity and creating comparisons relate to Knodel's break characteristics (explained above). Separate groups can be conducted with men and women or with younger and older participants either because that would encourage their comfort level in the discussions or because you were interested in comparing potential differences in their perspectives on the topic at hand.

4. Recruitment can be problematic. Many researchers assume that participants will show up simply because a topic is important; experience suggests that it doesn't take much for someone not to show up, even if you talked to them on the phone and they said "yes."

However participants are selected, experience suggests that 40% will be enthusiastic and eager to share insights, 40% introspective and willing to talk "if the situation presents itself," and 20% apprehensive and will share only minimally, if at all. (Krueger 1994, 109). Incentives can help attendance: participants can be paid an honorarium, given a gift certificate or a meal.

■ How many participants should be in a group?
The recommended number is 6-12 participants with 6-9 considered ideal. (Krueger 1994, 78). Jarrett interviewed 82 women in ten focus groups in her study of low income women. Kerth interviewed 78 men in ten groups, although she reports "a typical focus group had 5 to 8 participants." (1993, 108). Being an action research effort, the MCHP focus groups varied according to the number of people encountered in organizational or community meetings, the median being 7. (Plaut, et al., 1993, 206).

■ How much time is needed for interviews?
As much time as you need to have the questions fully discussed by the group. The literature and the MCHP staff agrees that 1½-2 hours seems to be best.

■ Is there a strategy for focus group question design?
Yes. Krueger suggests 10-12 questions for a 2-hour interview, broken down into 1) an opening "round robin" question, which identifies the characteristics participants have in common; 2) introductory questions, which allow participants to reflect on past experiences that relate to the overall topic; 3) transition questions; 4) 2-5 key questions; and 5) ending questions that bring closure to the study. (Krueger 1994, 54-55). The MCHP used the six questions listed below. Morgan believes 10-12 questions to be:

> "a little high. I think the real issue here is the purpose of the research. If you are looking for breadth, then 10-12, distributed as you suggested, will cover a wide-ranging set of issues on a topic. But if you are looking for depth, then it would be better to use a smaller number of questions, with follow-up probes to extend the discussion of each. One way I think about this is in terms of how much time there is to hear from each participant on any given issue. With 90 minutes and 9 participants, each person has an average of 10 minutes of 'air time' in the group. So, I would say that some projects use 5-6 questions to allow participants more time to talk about the issues involved in each question, while others use 10-12 questions, in order to hear what the group has to say about a wider range of issues." (Morgan 1994).

The design of focus group questions is critical and requires careful planning. (Morgan (1988, 1993) and especially Krueger (1994) provide considerable detail on this subject. At the start of a focus group, subjects are not sure of the researchers' agenda and can project their own needs/views into their understanding of a research project's purposes. The moderator therefore needs to provide a clear, comfortable, and credible description of the project and its goals. The first question must validate the moderator's introductory description by setting both the tone and direction for the session. The question should begin a process in which participants can "feel each other out" by sharing non-threatening information. It should provide a base for growing cooperation and mutual trust among participants. The first question for the MCHP focus groups asked only for hearsay:

> "What personal health problems or physical complaints appear to be most commonly mentioned by people in the community?"

The question enabled participants to compare their own "field notes" about what they had heard from the neighbors. When the group had "warmed up," the moderator tightened the focus for the remaining questions:

- What barriers to health care or medically-related issues do people in the community talk about?

- What in this group's opinion are the serious health problems in the county? What are the causes of these serious health problems? What in this group's opinion are the serious barriers to health care?

- What needs to be done to alleviate these problems?

- Do you feel that there is any group of the population not receiving adequate medical care? Why not?

- Who do people call in this community when they need help or advice? (Plaut, et al., 1993, 207).

O'Brien (1993,109) used a similar "funneling sequence" (Kahn & Cannell, 1957) of three questions for a study of AIDS and sexual behavior. He started with a general question: "How is your life different because of the HIV/AIDS epidemic?" Secondly, "When people get involved sexually, why is it that sometimes they have safer sex and sometimes they don't?" Then came the researchers' central question: "What are some things other people have done that you have found supportive in dealing the HIV/AIDS epidemic?" When group process had created enough trust, they also asked "How can we best recruit men for the large-scale, questionnaire phase of this study?"

◼ What makes a good moderator?

Moderators need to be able to:

- have a good memory.

- communicate clearly in speech and writing.

- be acceptable to focus group participants.

- demonstrate respect for the participants.

- make participants feel comfortable and supported.

- explain the purposes of the research.

- demonstrate enthusiasm about the project.
- demonstrate knowledge about the subject and the participants' world.
- explain how the data will be used and who will have access to it.
- clarify each question for participants.
- facilitate and guide discussion by being able to
    - prevent domination of discussion by an individual or subset of the group.
    - model good listening.
    - maintain a neutral, impartial role.
    - avoid answering or addressing issues raised.
    - provide positive reinforcement for participant input.
    - keep the discussion focused without dominating it.

Morgan (1994) told us "The question I always get asked is, 'How much experience or training do you have to have to do it?' I try to get people to think about their background in working with groups. Have they taught a Sunday school class? Have they chaired a committee? Coached a team?, etc. How much experience do they have with interviewing, possibly from their work or being on various 'search' committees? In other words, what can they find in their backgrounds that would give them some faith in their own skills as a moderator?"

What do moderators need to watch for in their own behavior? Common errors are talking too much, not allowing silence to "work," leading participants, and advocating a position or solution.

▓ Techniques for conducting focus group interviews

A team, including a moderator and an assistant moderator, is recommended. The MCHP had a male/female team, trained to alternate roles according to the make-up and predisposition of a particular focus group. For example, volunteer fire department males appeared uncomfortable with female moderators. The assistant moderator was responsible for taking the most complete notes, but the moderator also took notes. Each team person wrote up his or her notes within 24 hours of the interview. They then compared notes and together developed the final record of the interview.

Tape recording the focus group is a more precise method of gathering data. The assistant moderator still takes notes, but also can record numbers on the tape player's counter at which particularly valuable insights or quotes can be located at a later time. Tapes must be carefully handled and stored, however, to insure participant confidentiality.

▓ Enhancing validity and reliability
- Pretest focus groups questions as you would a survey.
- Use the same moderator and assistant moderator for each group.
- Maintain consistency in questions between groups.
- Have findings reviewed by focus group participants and/or a community project review board.

■ Analyzing your data

Determine the depth of analysis in terms of how results will be used. Data for policy making requires considerable in-depth analysis, while data used for community assessment or entrance strategies might require less rigor (and expense).

Krueger (1994) suggests four levels of analysis, together with the time required to work with data gathered in three focus group sessions:

1) Transcript-based analysis requires transcribing recorded tapes. Transcripts may run 50-70 pages and take as much as 48 hours to prepare. Analysis may require an additional 48 hours.

2) Tape-based analysis, in which the researchers carefully listen to the tapes and write a 5-10 page summary, is considerably less expensive. Some 12-18 hours are needed for analysis and development of a first draft summary.

3) Note-based analysis relies on "field notes, a debriefing session, and summary comments at the end of the focus group. The focus group is taped, but the tape is used primarily to verify specific quotes" (1994, 143). Eight to 12 hours would be needed for analysis and the writing of a preliminary report.

4) Memory-based analysis is used in market research where "clients," who have watched the focus group through a one-way mirror, are given an oral report by the moderator immediately after the session.

The Madison Community Health Project faced unique circumstances with 40 focus groups being conducted in rural Appalachian communities among people who often knew each other and were not comfortable with "outsiders." Both suspicion and physical circumstances made taping problematic, forcing research staff to rely on field notes. The lack of audiotapes required especially careful note taking and incurred the loss of ability to check quotes against a tape during analysis. However, the MCHP staff felt that the large number of focus groups (40) in the study compensated for the lack of tapes and provided an adequate cushion for reliability.

Each focus group session was written up in narrative form by both moderator and assistant moderator within 24 hours. The two accounts were then compared and consolidated into a single report. Reports were subjected to a content analysis to transform the qualitative data into a quantified form. Each health problem or issue mentioned by a focus group was coded as a separate variable, totaling some 230 items. Variables' values ranged from 0-2, "0" meaning no mention of a particular topic, "1" indicating that the issue had been raised but did not have apparent group consensus, and "2" indicating apparent group consensus. The staff was concerned that the appearance of consensus on an item might mask hidden individual disagreement. To compensate for such repressive "peer pressure," each participant was given a written copy of the questions and encouraged to write out private, individual responses. Variable scores were reduced from "2" to "1" in several instances due to written responses which were at variance to the group.

Variable scores for the 40 focus groups were ranked in descending order and the results became the basis for the MCHP Consortium's project planning.

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Focus group results can be combined or "triangulated" with other research methods to obtain deeper insight.

Focus groups can be used by themselves as a qualitative methodology to uncover perceptions, knowledge, and opinions. They also can be used in conjunction with in-depth interviews with individuals, the latter providing data repressed in a focus group. In the MCHP study, the community-based focus groups avoided mention of health problems associated with alcohol use and family violence, issues which were highlighted in focus groups with human services and health professionals. Individuals from the community-based groups also mentioned these problems to the moderators privately after the focus group sessions.

Focus group qualitative data can be supported by quantitative, statistical data from agencies such as the Census Bureau, the Centers for Disease Control, Uniform Crime Reports, and state and local government. MCHP focus group results were supported by quantitative agency data, which helped legitimize research results in the eyes of community members and funding sources. Triangulization (the coordinated use) of focus group data with other sources provides a broader, comparative data base. (Denzin 1970,1989).

When triangulating focus groups (or interviews) with survey data, timing is critical. Surveys can be timed with focus groups in four ways:

a) Focus groups can be used before surveys, to develop and refine survey questions.

b) Focus groups of survey respondents can be used shortly after a survey to both evaluate the survey process and interpret results in greater depth.

c) Focus groups not involving survey respondents can be conducted after a survey to corroborate and interpret results.

d) Surveys and focus groups can be conducted concurrently to gather both qualitative and quantitative data at the same time.

> "Survey data and transcribed texts from focus group discussions could then be analyzed together or independently, according to the research design." (Wolff, et al., 1993, 121).

To sum up . . .

Quantitative data gathered from surveys and governmental sources provide statistical summaries, such as mortality rates or opinion (percent of a sample approving or disapproving of a person or policy). *Qualitative methods* provide data on understandings and interpretations that guide behavior and thus can strengthen interventions designed to impact behavior. Qualitative methods also assist project evaluation by revealing how an intervention has been received, understood, and interpreted by the community and participating agencies, organizations, and individuals. Focus groups are a powerful and efficient qualitative method, especially when used in conjunction with data gathered in individual interviews and from government agencies.

Case Study: The Madison Community Health Project

A community-based health initiative based on coalition building began in Madison County, North Carolina, in August, 1989, with assistance from the W.K. Kellogg Foundation. The following is a case study of the project and its outcomes.

The Setting

Located along western North Carolina's mountainous border with Tennessee, Madison County consists of a 456 square mile area with a population of 16,953 living in some 6,514 households. Historically, Madison has been a county of family farms where burley tobacco has been the major cash crop. But in the 1980s, major tobacco companies turned to cheaper overseas suppliers, while demand for tobacco also dropped. The number of farms in the county decreased 11.8% between 1982 and 1987. Of the remaining 1305 farms, 1142 (87.5%) had incomes less than $10,000, indicating that, for most people, farming has become a second source of revenue behind what county folk call "public work" in commerce, industry, and government. The county's isolated and mountainous terrain has limited the development of a manufacturing industry. The consequent lack of economic opportunity has led to flight of the working age population leaving a higher percentage (14.4%) of people over 65 (the state average is 10.2%). Forty percent of its elderly live below the poverty line. Some 15.5% (757) of the county's 4,881 families live in poverty.

The Madison Community Health Project

The Madison Community Health Project (MCHP) was based on the Community Oriented Primary Care (COPC) model developed by two physicians, Sidney and Emily Kark, while working among the Zulu in South Africa in the 1940s. The Karks defined a four-stage process:

1) identifying the community — meaning the total population, not just users of the medical center. Studying the community, including its social institutions, structure and patterns of relationships, traditional healing methods, diet, and economy;

2) identifying community health problems;

3) involving the community in determining priorities in health needs and designing and implementing consequent health interventions; and

4) ongoing evaluation of projects to monitor their effectiveness and enable their ongoing refinement of efforts. (Kark 1981; Nutting 1990; Trostle 1986).

The first goal of the Madison project's assessment process was to determine how residents defined and used the idea of "community." The county's three postmasters were asked to map communities within their zip code areas. Their maps were then validated and refined by key informants. Residents defined their communities as small neighborhoods, based on traditional kinship ties and land holdings. A total of 72 communities were identified, along with 350 "community helpers" (defined as people whom residents of a specific community would call if they needed advice or assistance). See map of 72 communities on page 33. In sum, residents defined the traditional, kinship-based neighborhood of the mountain "cove" as "my community." The mapping exercise emphasized that MCHP should not plan for "community organization" because there were plenty of communities already well organized in frameworks comfortable for their residents. The challenge would be to **network** community groups together for collaborative planning and action.

The fragmentation of the county by its mountainous geography, its 72 subjectively-defined communities, and its various agencies required that as many groups as possible be included in a survey of needs. Consequently 40 focus group interviews were conducted — 7 with teachers; 8 with social services, mental health, and community support personnel (the sheriff's office, Extension Service, day care, and congregate meal site staff); 11 with medical providers; and 14 with community groups.

The interviews were conducted between August and December 1989, involving 416 participants. The setting for each group was its own turf, be it a school, a fire department garage, a church, or an office. The size of each group was determined by interest and its membership; the median was 7 participants. The community groups proved to be a source of data and also a means of involving people in the project's Community Advisory Board (CAB) and its interventions.

Interview Questions and Results:

Focus group participants were asked:

- What personal health problems or physical complaints appear to be most commonly mentioned by people in the community?

- What barriers to health care or medically-related issues do people in the community talk about?

- What in this group's opinion are the serious health problems in the county? What are the causes of these serious health problems? What in this group's opinion are the serious barriers to health care?

- What needs to be done to alleviate these problems?

- Do you feel that there is any group of the population not receiving adequate medical care? Why not?

- Who do people call in this community when they need help or advice?

The data gathered in the group are as follows:

Health complaints most heard in the community related to pain, which was associated with arthritis/rheumatism and backache, allergies, and heart disease. When focus group members were asked for their own opinion of serious health problems in the county, diseases related to aging and the frail elderly topped the list (Alzheimer's disease, circulatory problems, cardiovascular disease, and "just getting old").

The highest score in a question on a **group's own views of serious illness** was alcohol abuse. Stress-related symptoms such as head and stomach aches were ranked second to alcohol. A number of informants talked about the stress felt by farmers, who must produce to make payments on farm equipment and land taxes before they can provide food, shelter, and medical care for their families. The harsh demands of life for many county residents caused depression to be scored within the top five ranked health problems. Teachers said that family problems caused stress-related illness among children and depression, especially among high school students who see little opportunity after graduation: "They want to stay in the area, but have to leave if they are going to find jobs."

The **causes of health problems** cited were lack of preventive health care, lack of care of self in the early stages of an illness or injury, poor diet and poor parenting, poor hygiene, and abuse and neglect.

What should be done to alleviate the problems of poor health and inaccessible health care? Although there was general discussion about the need for a federal response to the health care crisis in the United States, the focus groups were encouraged by the facilitators to center their answers on what could be done locally. Consequently, **preventive health education** scored highest among needed solutions, followed by transportation for the elderly and for children, education on how to utilize existing health care services, preventive care, parenting, nutrition, expanded home care services for the frail elderly, and development of support groups for parents.

Groups cited as not receiving adequate care were the elderly, people unable to qualify for publicly assisted care and unable to afford private insurance, people who feel they can't

afford medical care, children, people without means of transportation, and people not educated to access health care.

The power of the small groups testimony lay not just in the aggregated tallies listed above, but also in respondents' descriptions of circumstances and conditions. Some examples, taken from group interviews with teachers, are:

- "We can't teach as much now as we did ten years ago — we spend much more time now...trying to control their behavior."

- "The [children's] stress comes from just trying to survive. Many [children] work in the tobacco fields and in tomatoes."

- "Kids don't sleep at night. They just come in here and put their heads down on the desk — and we let them sleep. They can't learn anything when they're that tired. We just let them sleep. Some of them stay up because they're working — in tobacco in the evening or digging night crawlers to sell to tourists."

- "[Due to the combination of the timing of factory shifts and single parenting] some children as young as the third grade are preparing their own meals. Some as young as the third grade have to dress and feed their younger brothers and sisters before school."

- "Kids are affected by alcohol abuse — both in terms of witnessing heavy drinking and by being victims or witnesses of physical abuse accompanied by drinking."

- "In my first ten years, I never made a report to the Department of Social Services for suspected abuse. Now we have to report four or five cases every year in this one school alone."

- "Fifty percent of the kids at this school do not get taken to the doctor. Mothers work now. They send sick kids to school. Single parents can't afford to lose a day's work and stay home with a sick child."

- "Fifteen out of the 25 kids in my classroom have never seen a dentist."

- "Dental care is a big problem. How do I know? Just look in their mouths — you can see the cavities. One boy has a large cavity in a front tooth and he always tries to hide it by holding his lip down over his tooth."

Focus groups allow a group synergy to develop, enabling feelings and insights to be expressed that could never be uncovered by conventional research methods such as individual interviews and surveys. The group process enabled resentment toward local physicians to be expressed by volunteer firemen and emergency medical personnel:

- "The boy's body lay in a ditch for three hours before a medical examiner (a job rotated by local physicians) would let us move him."

- "It took them an hour and forty-five minutes for a medical examiner to move K's body to the funeral home. We had to sit there and watch the 'Ooh-ahh' crowd stand there and stare at the body. The doctors don't take any pride in helping the ambulance service in a wreck."

- "The doctor charged me $35 and then told me, 'You have to stay out of the dust for a while.' Now, I'm a farmer. How am I going to stay away from the dust?"

In sum, the group interview process revealed that improving health services required that relationships among providers be improved.

Other Data

The group interview data was compiled alongside epidemiological statistics on mortality and morbidity and on demographic and economic data provided by both Federal and State agencies. For example, the county death rate in 1986 was 9.04/1,000, compared to a state rate of 8.62/1,000. Heart disease was the leading cause of death and had a rate of 317/100,000; the state rate was 306/100,000. Perhaps the most interesting finding in the epidemiological data was that Madison County is not atypical — its overall health is no better or worse than other American counties. However, an elevated diabetes mortality rate indicated a need for more attention to medical care and monitoring, and diet. An elevated pneumonia/influenza rate (51.84/100,000 compared to a national 29/100,000) suggested greater attention be paid to respiratory illness and preventive measures such as influenza and pneumococcal vaccinations. Data on dental caries (27% to 63% of K-8 students in the county's eight schools), indicated the need for dental sealants and other preventive care.

Interview scores were totaled and ranked and, along with morbidity and mortality data, fed back to the project Community Advisory Board (CAB). The CAB began as a small group of residents and county agency representatives involved in the proposal writing that led to the W.K. Kellogg Foundation's funding of the project. In the first two years of the project, the CAB grew from 25 to 40 people, representing most county public and private service agencies as well as community groups. Guided by the data, the CAB initiated a series of grassroots interventions in early 1990:

- Flu and pneumonia vaccinations for people over 65.

- Annual health fairs for seniors, which reached more than 500 people annually.

- Support for parents of newborn children in a pilot school district by specially trained community "lay volunteer" women recruited by the Parent Teacher Association (PTA).

- Forums for high school seniors on AIDS, stress, and stress management.

- Co-sponsored forums on national health care reform and infant mortality.

- A newspaper column on health issues, written on a rotating basis by CAB members.

- An oral health program for school children, including the placing of dental sealants.

- Published resource guides for parents and senior citizens.

- Written grant proposals including two that have funded the installation of a 911 emergency response system and the development of a diabetes education and control program.

From Advisory Board to Health Coalition

The experience of evaluating community-wide data and designing and implementing community projects over a four-year period gave Community Advisory Board (CAB) members a shared history of achievement and a new collective identity. Some of them had come together initially in the summer of 1988 to discuss the possibility of applying for the W.K.

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Kellogg Foundation funding. They hosted a foundation team site visit several months later and when the grant was awarded they were called together again and asked if they wanted to accept it.

Leadership during this initial phase was provided by a physician at the Mountain Area Health Education Center, who later became the project director; the chair of the local community-based medical centers; and a sociologist teaching at a college within the county, who later took responsibility for the community assessment process. The physician, sociologist, and project coordinator, a local resident with years of experience in the county working with the developmentally disabled, became the project staff, guiding the CAB through an orientation to the Community Oriented Primary Care process and community assessment during the fall of 1989. The staff presented community assessment data to the CAB in February and March, 1990.

A nominal group process was employed to break CAB meetings down into small groups to discuss and prioritize needs and actions, which were then voted on by the plenary group. It was at this point that the staff began to step back and turn project leadership over to the CAB.

Within several months the board had established subcommittees to deal with specific projects, such as an annual Senior Health Fair, and group issues (the Subcommittee on Children's Health and Parenting). A Long-Term Planning committee was established that eventually guided the CAB into its post-Kellogg project life as the Madison Community Health Consortium. An area resident with skills in meeting management was hired as a consultant. She trained members to facilitate meetings so that by the summer of 1994, MCHC meeting facilitation was rotated among volunteers.

Evaluation survey results reported that "93% of the members responded that they are **almost always** or **often** enthusiastic about being a part of the CAB...over 85%...signified that the COPC project had helped them make use of community resources...63.3% rated the CAB as **very productive**, while the remaining 36.7% indicated it as **somewhat productive**." The high morale of the CAB was indicated in the study by comments like "meetings are informal and members feel free to express their opinions" and "[members have] freedom to share ideas." (Shaler 1992).

By the spring of 1992, the Community Advisory Board had grown beyond the Kellogg COPC project it had been created to advise. It applied to other foundations to fund new interventions. The group renamed itself The Madison Community Health Consortium, "a partnership that seeks to improve the overall health of Madison County citizens by network-ing community agencies and groups in the ongoing process of needs assessment and project development, implementation and evaluation."

The consortium scored a major success in September 1992, when it received a $220,000 grant from the U.S. Department of Health and Human Services for a 911 emergency tele-phone system, to replace a maze of 13 different emergency numbers, while offering emer-gency and injury prevention programs for county residents. The grant not only provided important and needed services, but affirmed the validity of years of collaborative efforts culminating in the winning of a competitive national grant (there were 260 applications for 27 awards). When the receipt of grant funds was threatened by county politicians, the consortium was able to mobilize residents and groups to let the commissioners know that the loss of Federal funds would not be tolerated. The 911 system went on line in November

1993. A year later, the consortium won a second Federal grant totalling more than $300,000 to help pay for the mapping and addressing required for a computerized "Enhanced 911" system, in which the location of an emergency call automatically appears on a computer monitor screen together with a description of the site and directions for getting there. (Enhanced 911 is important, especially in rural areas, because it saves lives by reducing ambulance response times.) For a second time, the Madison Community Health Consortium had demonstrated its ability to pull agencies and individuals together in collaborative efforts to compete successfully at the national level.

To sum up . . .

In the summer of 1989, a coalition building effort based on the Community Oriented Primary Care model was initiated in Madison County, North Carolina. It began with a community assessment, which led to a series of interventions determined by a citizen-based project advisory board. Among the interventions were a dental sealant program for school children, health fairs and immunization programs for senior citizens, educational programs for high school students, a weekly newspaper column, and a pilot education and home safety program for parents of newborn children. By the time Kellogg Foundation support ended in 1993, the project advisory board had transformed itself into the Madison Community Health Consortium, a network of some 30 agencies and community organizations which boasted more than 60 members by December 1995. Operating as a collaborative network, consortium members have written grants that have won over half a million dollars in grants for health-related projects. The consortium coordinates health fairs, programs for physical fitness, and drug abuse prevention. It was one of the first groups in North Carolina to be accredited as a Healthy Carolinians 2000 Task Force. Its fitness committee has been recognized as a Governor's Task Force on Physical Fitness. In sum, the consortium is the community — organized, empowered, and actively working to improve its health and quality of life.

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MADISON COUNTY
NORTH CAROLINA

YANCEY COUNTY

BUNCOMBE COUNTY

TENNESSEE

HAYWOOD COUNTY

Mars Hill

Hot Springs

French Broad River
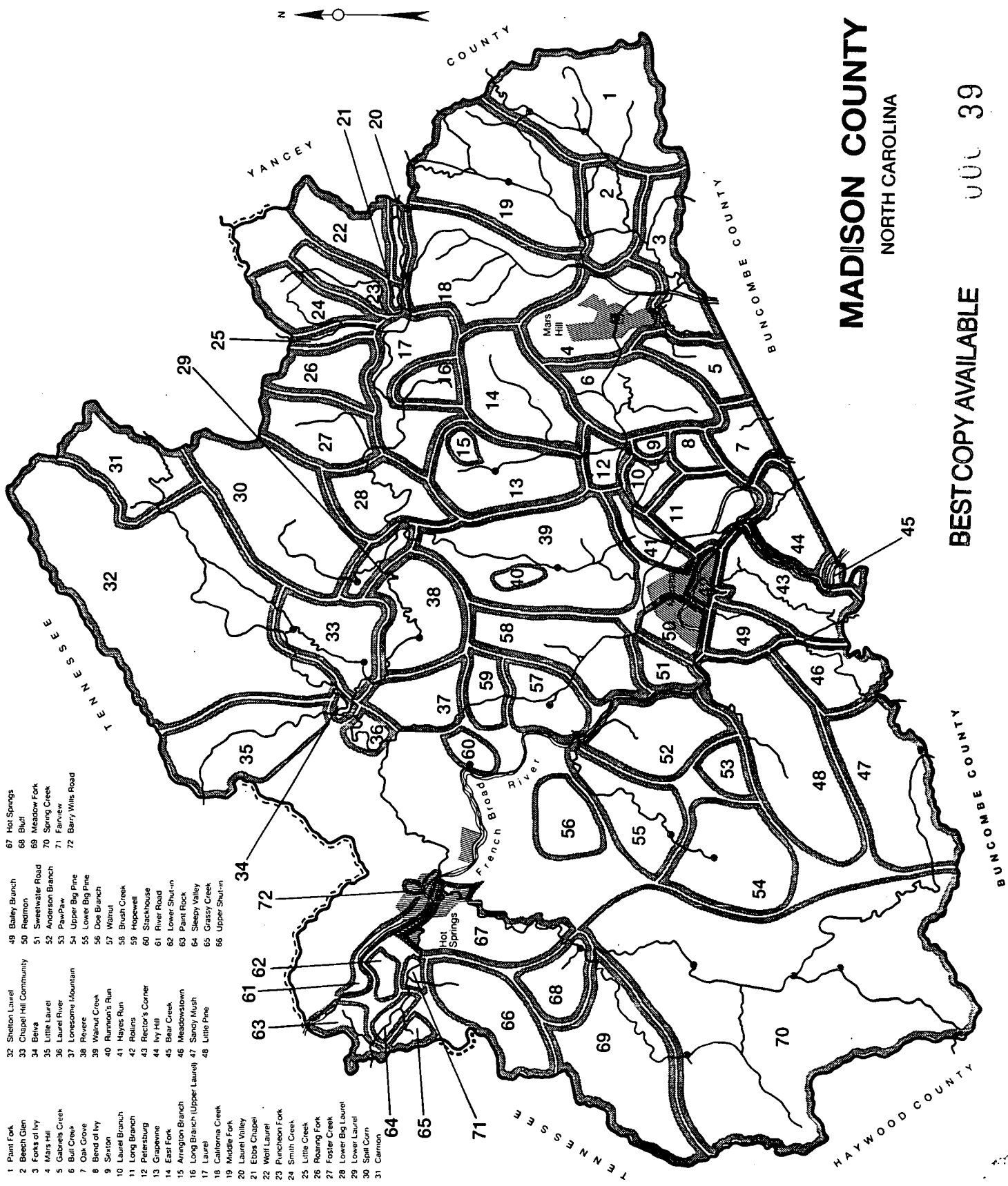
1 Paint Fork
2 Beech Glen
3 Forks of Ivy
4 Mars Hill
5 Gabriels Creek
6 Bull Creek
7 Oak Grove
8 Bend of Ivy
9 Sexton
10 Laurel Branch
11 Long Branch
12 Petersburg
13 Grapevine
14 East Fork
15 Arrington Branch
16 Long Branch (Upper Laurel)
17 Laurel
18 California Creek
19 Middle Fork
20 Laurel Valley
21 Ebbs Chapel
22 Wolf Laurel
23 Puncheon Fork
24 Smith Creek
25 Little Creek
26 Roaring Fork
27 Foster Creek
28 Lower Big Laurel
29 Lower Laurel
30 Spill Corn
31 Carmon

32 Shelton Laurel
33 Chapel Hill Community
34 Belva
35 Little Laurel
36 Laurel River
37 Lonesome Mountain
38 Bull Creek
39 Walnut Creek
40 Runnion's Run
41 Hayes Run
42 Rollins
43 Rector's Corner
44 Ivy Hill
45 Bear Creek
46 Meadowstown
47 Long Branch (Upper Laurel)
48 Little Pine

49 Bailey Branch
50 Redmon
51 Sweetwater Road
52 Anderson Branch
53 PawPaw
54 Upper Big Pine
55 Lower Big Pine
56 Doe Branch
57 Walnut
58 Brush Creek
59 Hopewell
60 Stackhouse
61 River Road
62 Lower Shut-in
63 Paint Rock
64 Sleepy Valley
65 Grassy Creek
66 Upper Shut-in

67 Hot Springs
68 Bluff
69 Meadow Fork
70 Spring Creek
71 Farview
72 Barry Wills Road

Panel Discussions

Our six years of work culminated in a conference on "Creating and Celebrating Community Coalitions" at Mars Hill College, Madison County, North Carolina on May 16, 1995. The morning sessions were devoted to panels on two crucial topics: culture and power structures and their relations to coalition building. The following two sections are edited transcripts of the panel discussions.

Panel I. Rural Culture and Coalition Building
What is "culture" and what is its impact on coalition building?

Culture is a way of life for people: their values, social institutions, world views, and consequent behaviors. Coalitions can network groups together only in the context of their culture and thus efforts that contradict or violate a community's cultural norms will fail. Understanding and being responsive to culture is crucial to success. We asked a panel to discuss rural culture, with an emphasis on traditional values and networking patterns in Appalachian communities. The panel included:

Susan Keefe, Ph.D.
Dr. Keefe is chairperson of the Department of Anthropology at Appalachian State University, Boone, N.C. She is recognized as an expert in mental health issues in the context of Appalachian culture. Her book, *Appalachian Mental Health,* is a standard reference for practitioners.

David Liden, Ph.D.
Dr. Liden is executive director and chief fund raiser for the Murphy Medical Center Foundation, Murphy, N.C. A political scientist trained at the University of Michigan, he has taught at Bethany and Wheeling colleges in West Virginia and at Western Carolina University.

Jerry Plemmons
Mr. Plemmons is a local resident of Madison County, N.C., the site of the Madison Community Health Project. He is on the N.C. Health Planning Commission's Advisory Committee on Rural and Urban Medically Underserved Areas and is the immediate past president of Western North Carolina Associated Communities, an eleven-county community development organization founded in 1946.

Tom Plaut, Ph.D., moderator
Dr. Plaut is a sociologist at Mars Hill College. He was responsible for community assessment and project evaluation in the Madison Community Health Project.

Plaut asked the panelists to focus on the characteristics often attributed to rural social systems:
* The family as the most central and important institution in individual and community life.

* The power of informal social networks and group relationships over individual achievement or task.

* The importance of egalitarian relationships and mechanisms for overcoming status differences and minimizing conflict in rural communities.

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He also asked about the implications of highly valuing family and community self reliance for coalition building. The panelists emphasized several themes:

1. Rural social systems are well organized informal networks.

2. Their organization often is not apparent to urban and professional people who tend to equate organization with formal committees, agencies, etc.

3. Rural social systems contain moral orders that highly value loyalty to family (familism) and to community and neighborhood, which is made up of complex individual relation- ships built around a variety of shared experiences over many years (personalism). They also employ various means for conflict avoidance, which can be expressed as basic equality among community members, cooperation, shyness, and modesty.

Sue Keefe gave a general overview of the rural values exemplified in the mountains of western North Carolina. David Liden applied her insights to his experience as a fund raiser in a rural mountain county. Jerry Plemmons provided a second case study in his description of building a coalition of communities around a primary health care program in a rural southern mountain county. An edited text of their presentations follows:

Susan Keefe

Coalitions should attempt to build on the natural social networks that are the basis of rural Appalachian community life. They should also build on the moral order — the value system — of the rural community.

People from urban areas have difficulty seeing organization in rural social systems, which is why mountain communities so often have been described as lacking organization. People from urban areas come in and see only homesteads dotted around the landscape. They see no concentrations of houses into towns and villages, and they say, "Well, there's a lack of community here." The fact is, it's a different kind of community structure, which is impor- tant to understand.

The first thing to note is that mountain people are organized. Rural communities in general are organized. We certainly don't have to go out and organize them! The important thing to do is to figure out how they are organized.

In Appalachian rural communities, every individual is tied into a network. Communities are organized by kinship (most important), friendship, neighborhood ties, and multiple shared experiences. Mountain communities are best conceptualized as webs that bind people together in multiple and complex ways, webs that are concentrated in geographic areas. A person who is your cousin is also your former schoolmate who lives in your neighborhood and attends your church. Ties are very strong and difficult to break. The advantage here is strength and group solidarity. Rural communities do very well in issue-centered political action; because they are networks, they can pull people together quickly. Since they are tied together by personal, face-to-face loyalties, when someone says, "Do this," people do it. These communities work well in mobilizing to prevent change; they generally don't work well in making things happen, in bringing about change. For example, we were able to save the Post Office in Sugar Grove by mobilizing local networks; on the other hand, we've been unsuccessful in bringing about a coalition to try to improve county schools.

Another coalition-building problem with close, personal rural systems is the great resistance given to people who want to break away from the group. It's also difficult for an individual to oppose or disagree with other people in his or her network. Another problem is that most rural mountain communities are small and the kinds of things they work on well are very

localized. Broader, meta-community coalitions require pulling members of different communities together for larger issues.

In terms of the moral order or values of the mountain community, **familism** is the most obvious; loyalty to family transcends all other relationships, obligations, and need for individual achievement. **Independence** — understood in terms of **self reliance** and the ability to take care of one's own needs — is important. **Egalitarianism** means that people are considered equal, even though there may be a difference in social/professional status.

Two values that need to be especially emphasized are **religion** and **avoidance of conflict**. Religion is central in the lives and thinking of mountain people. Urban folks often have a lot of difficulty tolerating the religiosity found in the mountains, but I would encourage them to do so. Religious values offer people strength and energy. For example, Maxine Waller is a local woman who got involved in the politics in Ivanhoe, Virginia, trying to save her local community after the mining and furniture companies left. She would go to county commissioner meetings with the Bible in one hand and a dictionary in the other. It's a great image of how mountain people use their faith in challenging uncomfortable circumstances.

Avoidance of conflict is a way in which people who live in small, close-knit networks are able to get along with each other for years and years — for life. They rather studiously avoid mentioning things that might produce conflict — that's the way they maintain the face-to-face communities. This can be weakness because important issues may not be addressed if they might create factions or disagreement in the community. On the other hand, avoidance of conflict can be a great strength because it can hold people together. They set aside things that divide them to pull together for the common good.

In summary, the moral order of the mountain community is something we all need to come to understand in order to work in western North Carolina. There are strengths and weaknesses here, as there are with any moral order, but what I would encourage is that coalitions build on the strengths of the existing moral order. We need to better understand the value system and work with it.

David Liden

My work for the past ten years has been fund raising. For the last four years I've been leading a capital campaign in the corner of the state that has never seen a major fund-raising project before. The campaign began ignoring the cultural context, violating some of the themes that Susan Keefe has just mentioned. As a result, the campaign just about self-destructed and we had to virtually redesign it and start over with much more sensitivity to the community in which we were hoping to raise funds.

Our facility, Murphy Medical Center, is a 50-bed hospital and 120-bed nursing home combined under one roof. In many ways, a modern hospital is an alien institution for a rural community. We should have realized at the very beginning that our hospital has taken over a number of tasks that were formerly done in a family context. Birth, healing, death, caring for the elderly traditionally took place at home. All of us working in a health care setting need to remember that we have replaced natural communities and families in many health care matters. This fact is symbolized every time a helicopter takes off with the most sick people of all, taking people away from the community to Asheville or Atlanta, Chattanooga or Knoxville. The helicopter represents in a very visible way the replacement of traditional community systems by "foreign" medical culture and technology.

An additional cultural problem lay in the fact that the Medical Center was seen as an institution run by outsiders. The hospital was opened in 1979. The administrative staff members were outsiders, the technical staff members were outsiders, and the physicians, excepting one, were outsiders. The equipment, technology, and language that go with hospital work are very different and unfamiliar to local people. It reminds me of the "town-gown" antagonism I knew in my days as a college professor. The Medical Center was not considered to be a part of the community. We began our fund raising without any sensitivity or awareness of the community's view of us.

We brought in a consultant — the "ultimate outsider" — to do a feasibility study and give us an idea of whether or not we could raise $1.6 million. The consultant sat down with plant managers, the county commissioners, the professional people, attorneys, etc., trying to get a sense of whether it was possible to raise $1.6 million in Cherokee and Clay counties. As he probed and tried to get an idea of the potential, local people told him what they thought he wanted to hear, because they value being hospitable — they had always been hospitable to outsiders and always tried to give the best impression of their community. The consultant consequently was convinced that we could raise the money using the traditional fund-raising pyramid: if you're going to raise $1.6 million, you need one gift at this level, three gifts at this level, and gifts at that level, and so on. All the small gifts are incidental. (You don't really pay attention to the flea markets and the bake sales because that's not where your big money comes from.) He convinced the hospital board that the old-fashioned fund-raising pyramid would work, that the major gifts were there. He then went around visiting donor prospects on behalf of the campaign and turned people off one after another.

The steering committee was ready to resign, the potential gift shrank, and the whole thing was about to die. There also was a lack of self confidence — the sense that "Well, that kind of money simply isn't here in our community; those kinds of resources simply aren't here." We discovered the campaign had violated a traditional community value of frugality; the consultant did it just by virtue of the way he dressed and talked. We found that the idea of a $1.6 million campaign seemed excessive to many people, who wondered "Why does the hospital have to raise money when they charge so darn much anyway? What do they need $1.6 million for? Let me tell you about my bill from when I took my kid to the emergency room last week!" And there was also an element that bothers me so much in my work — a natural sense of defeatism and self-deprecation (so often the worst scenarios bubble up) — as the campaign began to get off track, people began saying, "I told you so...there was no way you could ever raise that kind of money around here."

In short, we had a lot of repair work to do. We brought some new people in to try to figure out what was going on and whether or not there was a chance to raise the money or not. Let me tell you how we regrouped. We decided that we needed to earn the community's respect and that the community needed to understand the importance of this campaign and how it would benefit. We recruited new leadership, local folks who were trusted in the community because of their individual and family reputations. I took the hospital administrator to every barbecue, fish fry, and community meeting that I could find. It was the first time that the administrator had ever gone out into the community. They saw him. They saw that he was a real person and that he is a wonderful guy, a friendly guy. The hospital was proud of him and now the community is proud of him, too, because the community knows Mike, knows the administrator of the Murphy Medical Center for the first time. We stayed close to a radio personality in our community who understood the importance of the campaign and talked

about it all the time on the "party line" show. He came out to our fund raisers and did auctions for us. The community began to think, "If these people feel the campaign is important, it's probably all right."

We threw out the old timetable of getting it all done in 12 months and just plugged away at it. It took us three years. We broke down the $1.6 million into more reasonable, smaller goals. We organized community people around smaller goals: one group can probably raise $50,000 over time doing this and this and this. Another committee can raise $300 over a period of time doing something else. So we broke down the goals and made them more reasonable. We tried to enable and encourage people to use natural networks and affiliations, so fund raising occurred within community development clubs, churches, and volunteer fire departments. We went to groups that had been there for a long time and had credibility in the community. We built on a sense of place and sense of pride in who we are and what we could do by working together.

The fund raising campaign really came together when the Kresge Foundation offered us a $250,000 challenge to complete the campaign ourselves. In other words, we didn't get a dollar until we raised everything but the final $250,000. They gave us 12 months. That really energized the fund raising with a sense of, "Well, there's some snobby foundation out there in Michigan that doesn't think we can do it and, by God, we'll show them." We started all over again in the last 12 months and we did it. We went right down to the wire. We raffled off a pickup truck on the last day at the 11th hour. Clearly, the Kresge Foundation challenge was critical in motivating the community to achieve the $1.6 million goal.

Our sense of what we can do in our community is really different now. No matter what the nonprofit might be, we can do major fund raising. It was a wonderful, encouraging experience for us. I suggest that fund raising itself can be a tool for coalition building. This manual has a chapter on seeking grant funds, but you should not ignore the potential of local fund raising. When a fellow called me and said, "I don't have any money, but I've got a hog you can raffle off," I knew we were in the right place at the right time. We made $500 on that hog. I knew we had turned the fund raising campaign around and were on the right track.

Jerry Plemmons

I have the pleasure of chairing the board of the Hot Springs Health Program, a community-based primary care system that serves Madison County. It started in 1971 as a volunteer effort. It has grown to now being a self-supporting $5 million a year operation that includes four medical centers with eight physicians, home health, hospice, and pharmacy services; physical, occupational, and speech therapy through home care. We take great pride in what the community has accomplished. As board members, we are no more than caretakers of the community's investment in the program.

One of the things we've experienced over the years as this community has changed is the need to integrate new people coming into the community with lifelong residents. We've had to bring local grassroots leaders, who are very tied to traditional rural mountain values, together with other people who have moved in here as second home residents, retirees, or for other reasons. The newcomers are often better educated, articulate, and can be aggressive in their dominance of a meeting. Their rather confrontational style can differ in the extreme from the traditional modesty and shyness that is part of the avoidance of conflict behaviors of mountain people, who might not say much in a meeting, but their resentment grows over time. Resentment, as David Liden has just demonstrated, can destroy collaborative efforts. We have had to be very careful to make sure that traditional community folk feel comfortable

and have the opportunity to speak their minds. Partially, this involves making sure that they know that their opinions are valued and that they do have something to contribute to an ongoing discussion. This takes preparation; you need to anticipate cultural differences in planning a community meeting. Meeting design and management are critical in coalition building; the manual provided to each of you, *Building a Healthier Tomorrow*, has a chapter devoted to this subject. Coalitions are fragile entities. Good meetings are at the core of their "care and feeding."

Mountain folk value being self reliant and this has had real impact on the 24-year history of the Hot Springs Health Program. We started out as a volunteer effort, but later received Appalachian Regional Commission operating money in 1971 to pay staff salaries. We switched over to Public Health Service 330 funding in 1978. Part of that grant required that we have a sliding fee scale. A sliding fee sounds wonderful, but in a small rural community it caused real problems. Local folk wanted to be self reliant, in this case to pay their own way and be responsible citizens and, unless they are really destitute, they would not accept charity. They saw the sliding fee scale as charity and would not ask for reduced fees. But there were other people in the community who did not live by these values and abused the system. So invariably, by one means or another, the word got out into the community that "these folk, whom we all know don't deserve it, are getting reduced fees while these other folks, whom we all know do deserve it, are being charged the full price." That became a real issue. Partially because of this issue and partially because the Hot Springs Health Program Directors wanted it to become a self-reliant institution, we decided in 1985 to give up direct federal funding and become a totally fee-for-service program. This has caused problems because part of our mission is to provide services regardless of ability to pay. Some people thought that by giving up the federal money we were not going to serve the poorest folk. Over the past ten years, we have attempted to maintain the financial viability of the organization, but not in a way that deprived needy community members of services.

Another issue that developed along with the program was conflict between communities in the county. I agree with what has been said earlier about the valuing of conflict avoidance by people **within** a community. Internally, communities tend to work together. But, there is a tendency for small communities to see themselves in competition for reputation and services, as pitted one against the other. There often is conflict **between** small communities. If you have ever watched a school sporting event, you know what I mean. As the Hot Springs Health Program grew from the town of Hot Springs to having three additional medical centers located throughout the county, we had to be very sensitive to the fact that communities felt they were losing their ownership of the program. Many people in Hot Springs were uncomfortable when we moved the administrative offices from their town some 25 miles to Mars Hill. The program had "grown up" in Hot Springs. It carried the Hot Springs name and the Hot Springs residents had a real sense of ownership. Some people suggested that we change the name of the program, but we knew that would have been devastating to the people in Hot Springs, who were already unhappy with the move. Keeping the Hot Springs name helped lessen the sense of loss caused by the move.

David Liden's comments about fund raising are true in our experience in this rural county. Fund raising serves more than just generating the money to build a facility. Fund raising develops ownership in the community, which is as important as any money generated. We also benefit from the familism — loyalty to family and kin — that is so central in mountain culture. For example, we encourage children to honor their parents, living or dead, by making a contribution for a door or in a room in one of the four medical centers, which then

carries a brass nameplate with their parents' names. That brings in some financial support from children who welcome the opportunity to honor their parents.

Audience Comments, Questions, & Panel Response

"It really seems that it's not the agency-coalition connection that is so important, but rather the empowerment of the community. It should not be our agenda but the community's agenda. It's really important to focus on the empowerment building process of coalition building. Community people are not just recipients of coalition services; they are resources for those services."

"It strikes me that this meeting has turned out to be very white (and represents an elite of service providers). There are African-Americans and gays, bisexuals and lesbians in our communities. Despite the sense of equality that you have discussed there is also a heavy sense of community exclusion that affects those and other groups. What does this exclusion do in terms of coalition building?"

SUE KEEFE: Discrimination and prejudice can and do happen on a group level. However, personalism, the importance of individual relationships often overcomes group discrimination. For example, the relationships between Blacks and whites in mountain communities is usually friendly and neighborly because they are neighbors and have old family ties. In reality, you have both things — exclusivity and personalism — operating at the same time.

DAVID LIDEN: The division or exclusion factor in our community (Southwestern North Carolina) often centers around the local folks versus the outsiders or "implants." Consequently, we tried to build committees that were inclusive so that folks from the two factions were raising money side-by-side and getting to know each other by sharing the fund-raising experience. That's made a big difference. At the same time, those groups of people had different ways of approaching fund raising and we followed that natural inclination as well. Some folks might be more comfortable in organizing a flea market or barbecue or organizing a "womanless wedding." (Some of you may have womanless wedding traditions in your own counties; it goes back a long way in our county. Our doctors participated and made absolute fools of themselves. Local folks really appreciated professionals being willing to "play the fool." This dramatically improved our community relations.) Outsiders were more comfortable talking face-to-face. Local folks often preferred not to talk about money face-to-face; they didn't want to ask people to give money. They would do things to raise the money from their friends and neighbors without directly asking for it. The newer people, the "implants," were much more comfortable sitting down with others they knew from AARP, church, or whatever and saying, "Look, this hospital is important to us. I have the idea that you probably could make a $10,000 gift over a three-year period." So we let people follow their natural and cultural inclinations. But we had to know what those inclinations were and put those committees together and get people together. Having meetings at the hospital was also important. The only time people had been to the hospital was when they were sick or when a baby was born. But meeting at the hospital, touring the hospital — seeing the laundry, food preparation areas, and other things with the administrator — enabled them to relate to the hospital in a very different way. In this process of tours and meetings, different sorts of people with different backgrounds got to know the hospital and each other while engaging in a common task.

TOM PLAUT: In the Madison Community Health Project we found focus groups were an effective way of bridging the gaps between groups. Since a focus group by definition is made up of people sharing a similar background, it provides a forum for the expression of group views and feelings. A group we did in the fall of 1989 uncovered real anger and frustration on the part of volunteer firemen and ambulance personnel with physicians. When we asked what might be done to help the problem, one fireman said, "Nail their (physicians') feet to the floor and burn the building." Four years later, volunteer firemen and physicians could sit down and help write a grant proposal that funded the creation of the county's 911 emergency response system. In the intervening period, the firemen's frustrations had been shared with physicians, whose sensitivity and willingness to work together with community folk had helped develop a sense of trust and cooperation.

"Do you think mountain people have a significant reservoir of hostility that comes out in ways that are not very productive?"

JERRY PLEMMONS: Let me tell you a story. Several years ago there was a young actor and writer who moved into one of our communities. After being here a short period of time, he began writing satire about local mountain culture in our local newspaper, which didn't help the integration of insider/outsider groups. His articles had created quite a division in the community. I was out "on the creek" one day and ran into one of the old families and asked, "What do you think about the articles in the newspaper?" The lady said, "They made me mad as fire and I was ready to go out there and claw his eyes out. But then I was talking with Charles, who lives up there beside that boy and he said, 'Now Ruth, you've got it all wrong. He's a good boy. You just don't understand what he's trying to say. I'll tell you this about him: he's the best neighbor I've ever had.'" And she said, "That was enough for me. If he gets along with his next door neighbor, then I don't have any business opening my mouth."

"Afro American communities, even though they may be located in urban settings, have many of the same values and life patterns you have discussed here this morning. There is an emphasis on the family relationships and loyalty and strong religious values. Things get done through informal social networks."

JUNE TREVOR: Sure. People carry rural values with them when they migrate to the city. The Building a Healthier Tomorrow manual, although it focuses on coalition building in rural areas, should be helpful for those of you working among ethnic groups in urban areas.

Panel II: Coalitions and the Power Structure

What is the "power structure" and why are we concerned with it?

We define a "power structure" as those individuals, institutions, and organizations within a community that usually control decision making. Studies demonstrate empirically that "those with power tend to interact; and that key community decisions arise from this interaction." (Sofaer, 1992; Hunter, 1963).

Coalition building involves a new way of doing business in which priority setting and decision making are opened up to the larger community. Coalitions are the result of the empowerment of the community and are driven by the collection of community data and voicing of community needs. Decisions are made from the bottom up rather than from the top down. If this deviates from the way decisions have been made in the past, it can be threatening to powerful community leaders or powerful community agencies.

Effective coalitions will interact with the powerful, either internally within the membership, or externally in seeking sanction from local authorities. If truly inclusive, your membership will include the larger and more powerful agencies in the community, sometimes those in direct competition for resources or clients, and the smaller, less influential, entities. You will develop grants or health projects that will require the endorsement, active support, or involvement of elected or appointed officials — whether it's commissioners, town aldermen, Boards of Education, or Boards of Health.

How do you promote empowerment and include the powerful?

We asked this question of a panel of coalition builders, who could represent a variety of approaches to dealing with this issue. The panel included:

Carolyn Haynie, RN
Ms. Haynie is a Children and Youth Consultant with the N.C. Department of Health and Natural Resources. She was formerly Health Director and Nursing Supervisor with the Madison County Health Department and has been an active member of the Madison Community Health Consortium since its inception in 1989.

James Powell, MD
Dr. Powell is a practicing ear, nose, and throat physician in Asheville, N.C. He served as immediate past president of the Buncombe County Medical Society and has been integral in the Health Partners project in Buncombe County, an effort funded by the Robert Woods Johnson Foundation that has brought together physicians and other community members to look at ways of improving access to health care for medically underserved people.

Margaret Watkins, MT, MT (ASCP), MS
Ms. Watkins is the Lab Director and Project Assist Coordinator with the Appalachian Health District in Boone, N.C. She is also chairperson of the Watauga Healthy Carolinians 2000 Task Force, one of the first certified Healthy Carolinians task forces in North Carolina and the 1993 winner of its Thad B. Wester Community Award for creative action planning.

June Trevor, Moderator
Ms. Trevor is Project Coordinator for the Madison Community Health Project and facilitator of its health consortium.

Carolyn Haynie

MODERATOR: Carolyn, your coalition initially did not have much involvement from elected officials, such as county commissioners. What approaches has the Madison Community Health Consortium used over its five-year history to engage the support of these officials for coalition projects and the coalition itself?

CAROLYN HAYNIE: County commissioners had always been invited to the early consortium meetings. They weren't intentionally excluded. They did not come to the meetings, but it was the fact that they had been invited that is very important. One thing we've learned is that it may not be as important for them to physically be present, but it is more important for them to know about you and know what you're doing. When you do take on a project, it's a lot easier if they have some background on the coalition than for you to have to start at the very beginning and educate them.

Another reason that the commissioners may not have been as interested in the beginning is that our Kellogg funding did not come through the county government. Since commissioners had no control of this money, and did not have to administer this money, I think that they took more of a back seat position. Obviously, that changed as we took on certain projects (911, COMET, etc.) and they were technically responsible for the money.

I have several tips to share. I've looked at some different leadership skills that are very important with coalitions. These skills intermingle with the approaches that you need to take with existing power structures, too. You can see how they both come together.

Communication

Communication is critical. You have to keep elected officials informed, whether that means:

- getting on their agenda to update them about your project, (OR)
- going one on one.

There have been many times that I've been in the commissioner chairman's office and we'd be talking about a Health Department issue and I'd use the chance to say, "Oh, by the way, our dental sealant project is doing this," or "Our 911 project is doing this." That way, they could never say that they had not been informed if something did come up in a commissioner meeting. You never realize when you'll need their support, like when you need a letter of endorsement for a coalition project. It is hard when you go seeking a letter of support and they have no concept about your project.

If you're on the agenda for a commissioner meeting, most commissioners want to know before you get on the agenda why you're on that agenda — no hidden secrets, no tricky questions right there in public to embarrass them. I would be very up front with them, whether talking one on one, through phone calls, or telling them why you're on that agenda.

Credibility

When you're first starting out, take on projects that are not controversial, that can lend you some credibility. You can build on that success to take on projects that may raise questions from elected officials. One of the first projects we took on was the dental sealant project. That's a very benign project and it helps all the children in the schools, and provides a lot of education. When we approached the Board of Education, there was no doubt that they would support the project. Because of that success, we felt more comfortable going back to them with projects the consortium developed later.

Networking

I'm not only saying network with your community leaders and elected officials. I'm talking about networking *inside* your coalition, because there are a lot of hidden leaders. Your leaders are not necessarily in the courthouse. They are in the community. It's very important that you allow time during your coalition meetings to give people a chance to network. A lot of times we would come into these meetings and I could pull the DSS director aside and we were politicking! "Well, what have the commissioners done with your budget?" We all realized that we had a common interest and that we were all dealing with the same people and that we needed to work together. That really helped us to bond, to have that time to network.

Agreement building

You need to be able to compromise. You need to have some skills in conflict resolution and mediation. We had a success with the Board of Education when we approached them about dental sealants. We approached them again about doing a health risk appraisal on all teens. There were a few questions about sexuality, suicide, substance abuse that the board members thought were too controversial. We would have been crazy starting out with the health risk appraisal.

Start with something simple and then build on your successes. Not that you'll always have success. We ended up compromising in that we did not do the risk appraisal but we were able to do some group activities and provide some educational opportunities for high school students.

Exercise non-jurisdictional power

Now what do I mean by that? You've got to recognize where the power is *out in the community*. A lot of power obviously is in the media. Another place is public opinion. Some people don't think that public opinion is important, but in a rural community, it is *very* important.

I assure you that mobilizing this power base definitely works. We were faced with our 911 project already operationalized, but due to a shift in power among the commissioners, the new chairman had not been as involved with the project as the former chairman. There were some obstacles, such as concern over future county support for 911 dispatchers, and we were looking at the possibility of losing some 911 funding. Members of our eight volunteer fire department who had been involved with the development of this project called the commissioners to express their concern about the possibility of losing 911 in our county. Those phones rang all weekend. By Monday morning, the commissioner was ready to compromise and fix any problems that existed.

There is a French saying, "You have to be sure you want the consequences of what you want." Definitely, our consortium realized how important 911 was for our county, so we were willing to take on that battle and risk some real controversy with the commissioners.

Share the success

That gets into being able to empower others. Not only share that success with your coalition, but you need to share that success with your Board of Education, with your county commissioners, whether that means a picture of them in the local paper or a letter of thanks. It creates a larger network. It also includes the community. They see it. They see everybody working together. They see the success of being able to call and get a decision changed. That makes them willing to take on more activities too.

Be flexible
It's true with public health and it's true with coalitions! You have to be able to "go with the flow," changing directions and reworking ideas in order to get the outcomes you want.

James Powell:

MODERATOR: Dr. Powell, your Health Partners Planning Group has involved county commissioners in its membership from its inception. How has this affected the coalition's decision-making process? What are your recommendations to new coalitions about having elected officials represented on their coalitions?

DR. JAMES POWELL: Health Partners is still in the evolving stages. As we evolved, we sought to inform the community about what we were trying to do. It seemed important to include certain people, personalities, organizations that the community recognizes. I would emphasize three themes: **community, integrity,** and **reality**. I'll describe how we applied these themes in our project.

Community
In a broader sense, our Health Partners group talked about how to define community. There are many definitions for community. The Greek definition of community was that the community was whatever that individual would encounter if in a day's activity he ventured from home and came back and spent the night in his own home. That's not a bad definition of what community is now. For local purposes, those people that you encounter in your day-to-day undertakings is a very good definition of community.

Integrity
To help the community buy into the project, there had to be a certain amount of **integrity** in the process. The community already recognizes that there are certain people with integrity, position or power, such as county commissioners, so they were asked to join in the Health Partners process. We were fortunate that two of our five commissioners already had interest in what was going on with health issues in the community. So we had an easy task of convincing those two to come on board. Any process, project, or endeavor will sell itself if the integrity of the process is there and if the integrity of the people taking part in it is evident — in other words, if the effort is greater than the individuals.

Reality
The reality of our situation was that we needed to communicate with a community, particularly the different interests in the community that pertain to the goals of Health Partners, especially physicians and those people who we were targeting, the medically underserved.

The key to coalition success is when the welfare of the whole is greater than the welfare of the individuals. If people come and they join in the process and they see familiar faces and they see power brokers and they see politicians, then they say, "Hey, this might work for me." They come and have their own agenda and their own purposes, but they must bring to the group a willingness to participate with the overall coalition goals and accept the reality that the needs of the group and integrity of the group are greater than the individual effort, individual theme, or individual agenda.

The integrity of community health coalition work and involving the right people in the process is so important at this time, because health care reform is now back in the hands of the community. It's very much in the market place, in the hands of local business and busi-

ness entrepreneurs. I have always had a vision that communities should rise up and take up what their own health issues were and not leave it all to doctors and providers. The **community** should decide what it needs, not Raleigh and not Washington. Communities do not trust a process imposed from the outside. We have learned this lesson as a nation with the recent health care reform effort. The groundswell at the community level is what we need to tap to make improvements in health care access and services, paired with some federal legislation to help with affordability issues.

Margaret Watkins:

MODERATOR: Margaret, other factors in the local power structure are the boundaries or competition between different agencies. The collaborative nature of coalition work can be threatening to individual agencies and they will want to protect their turf. What strategies has your Healthy Carolinians task force employed to overcome "turfism" issues?

MARGARET WATKINS: An advantage of forming a Healthy Carolinians coalition, in which a model is provided, is that we did have some direction from the state. After our task force formed, Healthy Carolinians had an annual meeting with workshops to help guide us through the process. Up until this time, we were struggling. At the first annual meeting, we were presented with this wonderful manual on coalition building (*The Healthy Carolinians Guidebook for Communities*). And I thought why didn't they give us this at the beginning?

In looking back at this question of turfism, I'm glad we didn't have the manual. Because if you are looking for a particular formula that's going to work for your community, you're not going to find it. Only you know what's going to work in your community because you're there. This is especially true when forming coalitions around politically sensitive issues like tobacco use.

I wanted to share several points that are key to avoiding turfism:

Know yourself and your community
Only you are going to have a real feel, particularly in the rural mountain culture. For example, a lot of rural life revolves around the churches. To a lot of people, this is the "community."

Know who is at the table
Our Healthy Carolinians group meets quarterly and has divided into subgroups that help to funnel some of this energy from members' individual agendas into various health action plans. People who are interested in substance abuse work on the substance abuse committee. People who are interested in child and maternal work on that committee. There is very little control from the steering committee. It's frustrating because you want things to go faster. But you have to realize that the people on these committees have a coalition within a coalition and it needs to have its own process.

The Number One thing our group has discovered is networking. People had no idea what the others were doing. Resources are limited and people are more willing to share now. This knowledge also avoids duplication of services. Getting people into the same room without a formal agenda, just to bring their resources about what they do, is valuable to the whole organization. You come out with an understanding that you can together address one common problem within the community.

Know where you are going
None of us goes anywhere without road maps. This is where your mission, goals, and objectives help guide you. This is where the buy-in from individuals occurs. Unless your whole organization buys in, it's not going to buy into the whole project. If you get that done early on, then everyone is aware of the rules, which is my next point.

Know the rules
You need to have a voting process. Everyone needs to understand the decision-making process. Then when problems do arise, you have that to fall back on. Everyone knows how it's going to be done and it's going to be done fairly. This also builds trust and builds a true partnership.

The Maternal and Child Outreach project was one of our project's biggest successes. It brought together two local hospitals, the WAMI organization, and the health department. It was the first time that all those organizations had undertaken one project together. It's with this building that you end up with a true coalition.

Have a strong mission statement
If you don't have a strong mission statement, goals and objectives outlined, you really don't have a fair playing field. A lot of the issues can be resolved by steering them back to the original mission statement. Don't just **give** the coalition members a mission statement. Developing an agreed upon mission statement takes a lot of time and process, but it's got to be a mission that the entire group agrees on.

One of the issues that came up was with using the medical center vans for our maternal outreach project. The idea was to advertise the medical center's 800 number that people recognized for child and maternal health care. Some thought that the use of the van was taking away from some of the local hospitals. Consequently this was a real problem within that subcommittee. They went back to the original mission statement, which included "access to health care." Once they realized that the 800 number was really meeting our mission, then that issue was settled.

Networking enables fast responses to opportunities
We had an interesting experience. Our maternal and child health committee had developed its action plan and timeline, but there was no money for implementation. At one of our meetings, one of our participants brought in a request for a grant proposal and felt our group should respond. If the planning hadn't already been done from Healthy Carolinians, we would not have been in a position to respond and consequently get the grant. As a result, we have mobile units traveling a five-county area transporting mothers and children to needed services.

Know the groups that your coalition is trying to serve
You need to clearly identify your target population for interventions. We have a Hispanic population that was not utilizing the van. When the opportunity came to hire a new maternal health outreach worker, we hired a person fluent in Spanish and was Hispanic. Her involvement made a big difference in participation from this population. All she had to do was pull up the van and the people came out.

Be prepared for obstacles and opposition
Differences will arise. Recently, our injury control board passed a bike safety and helmet ordinance for Boone, North Carolina. But the measure was almost blocked. Referring back

to the power structure, it's important to know who will support your program. Spend time on strategic work.

Buy some "Fragile" stickers
Label your coalition "Fragile." It is evolving. It's going to change. You're never going to be able to put your finger on what's happening right now. For example, Healthy Carolinians is going through a transition now at the state level. It's important to nurture the coalition and help it evolve with these changes.

SUMMARY

The panelists' discussion presents several common themes that can serve as a guide to coalition builders in their efforts to work with local power structures.

- The integrity and credibility of a coalition are indicated by its ability to involve who it needs to involve to accomplish its goal. The reality is that coalitions need the involvement of the powerful as well as the populations served by the coalition to achieve changes at the community level.

- Formal and informal power structures exist in communities and both can influence decision making at the community level. Coalitions can strike a balance between formal structures, such as elected commissioners, and informal power bases, such as citizens' groups.

- Effective involvement of power brokers in coalition work can range from their active participation on the coalition to keeping them regularly informed of the coalition's work. Open communication is the key to engaging the support of the powerful, whether they attend meetings or not.

- Identify and know your stakeholders. Expand your "net" to include people who can help facilitate the process and who might block it at a later date.

- Mission is critical. Knowing what you are about will help lead the group through those murky waters known as turf issues.

- Networking within and beyond the coalition promotes trust and reduces the potential for turfism within the coalition or power struggles between the coalition and other entities in the community.

- Finally, we caution coalition builders to carefully review how decisions are made in the community and how to best interact with the powerful while ensuring that your coalition's decision making process is kept pure and reflective of community needs and its culture.

Facilitating and Managing Meetings

In an evaluation of the Madison Community Health Consortium conducted in 1991, members report that "neutral facilitation" was a factor for consortium effectiveness. The consortium meetings were characterized by open information exchange between project staff and members, ample opportunity for discussion, and decision making by consensus. Initially, the project staff led the consortium meetings and the project secretary took minutes. In 1992, a facilitator was added to the project staff helping with long-range planning, development of the mission and vision statement, and the transition from a staff-driven to a member-driven consortium. The long-range planning committee decided that following the Kellogg funding, consortium members could serve as co-facilitators for the meetings. In Fall, 1994, members volunteered to facilitate one meeting during the year and received training in meeting management and facilitation skills. The training emphasized planning agendas, managing differences, maintaining neutrality, and reaching consensus. Currently, the consortium meetings continue to be co-facilitated by members who are comfortable and skilled in the role of facilitator.

In this chapter, we will address the following questions about facilitating and managing meetings:

1. What are the key ingredients of an effective meeting?
2. What are the key roles necessary for an effective meeting?
3. What is the facilitator's role?
4. When should a group *not* meet?
5. What factors need to be considered before a meeting?
6. Who should be invited to a meeting?
7. How should the room be set up?
8. What decision-making strategies can be used in meetings?
9. What makes a good agenda?
10. What helps a facilitator move a group to a shared understanding?
11. What are ground rules or standards of behaviors?
12. How can the facilitator handle conflict and build agreement?
13. How can a facilitator, planner, or leader prepare to understand and manage cultural differences?
14. How should a meeting be closed?
15. Should a meeting be evaluated?

1. What are the key ingredients of an effective meeting?

Meeting participants need to feel welcomed and included in the process. Introductions are critical. A well thought out written agenda, with time frames and speakers noted, can serve as the meeting "road map." The meeting participants must have a common focus on content (the "what" of the meeting) and the process (how issues will be discussed). The facilitator is responsible for assuring that meeting participants are discussing the same issue at the same time using the same process. The facilitator also maintains an open and balanced conversational flow, makes sure that the standards of behavior adopted by the group are maintained, and that the meeting topics stay within the time allotted. Roles, responsibilities, and decision-making methods (consensus, democratic vote, or recommendations to another "authority") need to be clearly defined at the beginning of each meeting. At the end of the meeting, items that require action or follow-up need to be reviewed with specific responsibilities assigned. Plant a seed for the next meeting by reminding participants of the date, time, location, and special topics to be reviewed if known. (Doyle & Straus, 1976).

2. What are the key roles necessary for an effective meeting?

The **Facilitator** assures that discussion and group focus stay on the group task, clarifies what decision-making process will be used, and makes sure that everyone participates and is heard. The **Time Keeper** provides time-related feedback to help the group stay on task. The **Recorder** lists comments and points made by group members, develops a written group memory, and assists in preparing a summary of group discussion. **Group Members** are unencumbered by specific leadership tasks; their minds are most free for accomplishing tasks, generating ideas, sharing thoughts, and asking questions. Group members are the most vital part of any meeting. A **Secretary** takes minutes and distributes this record to group members in a timely fashion. If small groups are utilized for specific tasks (brainstorming, task forces, etc.), a **Spokesperson** serves as a reporter to other groups. Individuals can serve dual functions (e.g., a facilitator can also be the recorder).

The Madison Community Health Consortium had a paid coordinator who served as the meeting facilitator and a part-time secretary who took minutes. A facilitator was added to the paid staff during the grant period to facilitate long-range planning.

3. What is the facilitator's role?

The facilitator:

- is a neutral servant of the team.
- helps team members focus energy on task and stay on task.
- makes sure everyone has an opportunity to participate.
- enforces agreed upon standards of behavior or ground rules.
- is a meeting chauffeur.
- is a process advocate, makes suggestions on how to proceed.
- makes sure everyone is doing the same thing, in the same way, at the same time (gets process agreements).
- does not contribute ideas or evaluate group member's ideas. (Doyle & Straus, 1976).

4. When should a group NOT meet?

A face-to-face group meeting may not be appropriate when:

- a telephone communication would accomplish the purpose as or more efficiently.
- there is inadequate data or poor preparation.
- the subject matter is trivial.
- there is so much anger and hostility in the group that people need time to calm down before they can begin to work collaboratively.
- the subject matter is so confidential or secret that it can't be shared with all group members.

5. What factors need to be considered before a meeting?

Key questions to ask before a meeting are:

- How does this meeting fit into the overall plans or goals?
- How does this meeting relate to the last meeting and next meeting?
- What organizational or community events/issues will significantly affect this meeting?
- How will this meeting affect events or issues elsewhere? What are the connections to other meetings, task forces, community groups, etc.? (Doyle & Straus, 1976).

6. Who should be invited to a meeting?

A stakeholder is any person (or group of people) who is responsible for the final decision, is likely to be affected by the outcome, or is in a position to prevent a decision from being implemented. A key question to ask is: Who do I (we) need in this meeting to make it successful? Identify final decision makers, people affected by the outcomes of the meeting and people who have the power to assist or block a decision. Identify for each person or representative, what he or she might want from the meeting, how he or she can "win" by being a part of this meeting. Invite participants to include all key stakeholders to represent all points of view. (Doyle & Straus, 1976).

7. How should the room be set up?

The arrangement of the room can either contribute to or hinder a group's effectiveness during a meeting. Make sure that everyone can see the wall space or easel for the group memory. Chairs should be movable so all group members can focus more easily. Tables are helpful for those who want to take notes. Make sure there is adequate space and chairs. If you are using audiovisual equipment, check the equipment prior to the meeting.

8. What decision-making strategies can be used in meetings?

Some decisions are announced by the leader/facilitator because they were decided by another group. ("The State Health Department has announced...") The meeting's function may be to tally input and pass the feedback on to another group or governing body. ("The School Board would like this group's input about the pilot after-school program...") A consensus-seeking decision is one that group members feel heard and understood by the rest of the group. Each member must be able to "live with" the decision, solution, or prioritization, and all members must be willing to commit to their roles in carrying out the decision or implementing the solution.

Consensus-seeking does not necessarily mean 100% agreement. It is a process of exchanging ideas and reaching an agreed upon decision, solution, or prioritization. If the group is attempting to use consensus-seeking there should be a fall-back mechanism if time runs out at the meeting. The decision could be tabled until the next meeting, delegated to the task force or committee, or delegated to the governing body or identified leader. Groups can also vote using a democratic process. Factors to consider in choosing a decision-making option are:

- How much time is available?

- How important (or trivial) is the issue?

- How much information and expertise do group members have?

- How much participation is necessary to ensure implementation?

Consensus-seeking takes time but increases the commitment of group participants. Commitment is needed to support important decisions. If consensus cannot be reached, voting or other "fall-back" methods can be employed to reach a decision.

Nominal group process helps to encourage more participation from members. Members are divided into small random groups and given an opportunity (5 minutes) to write notes or comments about the questions presented by the facilitator. Each small group facilitator records on a flip chart the exact idea presented by the member and verifies what is written with the member. This is an opportunity to capture ideas, not to evaluate or rank the ideas. Members can "pass" if they choose but should be encouraged to contribute in the second round. Ideas are generated until all ideas are exhausted or repeats are encountered. The facilitator asks for a brief statement or clarification on each item and helps guide the group to identify duplications. Items can be combined or deleted if the person suggesting the idea gives agreement.

After the discussion is finished, the facilitator leads the participants in choosing, in order of preference, their top five items. Each person ranks his or her top five choices, giving a "5" to the highest priority and a "1" to the lowest priority. The facilitator goes "round robin" and tallies the rank for each item. The facilitator prioritizes the list; the item receiving the most points is the first priority. The top five represent the group's consensus on priorities. Small group results are presented to the full body, where the process is duplicated and items prioritized again.

Nominal group process and modified versions allow for more independent thinking. Members who may be reluctant to talk in front of a large group may appreciate the opportunity to discuss and exchange ideas in a small group. Often good ideas come from merging two people's ideas and capitalizing on the creative problem-solving of a group.

9. What makes a good agenda?
An agenda is a road map that guides a group through its tasks and decision-making. The agenda should identify what will happen, how it will happen, who will lead the discussion/ activity, and the time allotted. Make sure there is adequate time so each topic can be addressed in the necessary depth. The facilitator's responsibility is to use the agenda to help the group stay on task and to contribute appropriately. Each agenda item should have an identified desired outcome that can be expressed. A desired outcome is a concise statement of the end result or product of the agenda item. The desired outcome should be stated from the point of view of the participant. It should be brief and identify the end result or product of

the agenda item (if the agenda item is information sharing, then state the purpose of the information). (Doyle & Straus).

10. What helps a facilitator move a group to a shared understanding?

A facilitator's attitude helps move a group to a goal, as well as the establishment and use of meeting *preventions* and *interventions*.

A facilitator needs to remain neutral or detached from the content of the meeting, deferring his or her own thoughts, opinions, and feelings about issues. The facilitator needs to demonstrate a belief that agreements are possible and desirable. The facilitator is an advocate for decisions that everyone is willing to support. The facilitator needs to remain flexible about time, issues, and process constraints, and open to changes. It is helpful to remember Margaret Mead's statement: "Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has."

Interaction Associates, Inc. of Cambridge, Massachusetts has developed two useful "tools," preventions and interventions, that help facilitators keep meetings on track, avoid potential problems, and intervene when necessary.

Preventions are facilitator behaviors used at the beginning of a meeting or during a meeting to help get the meeting on track and avoid potential problems:

- Establishment of a shared vision and mission for the group — are we including everyone's interests?

- Establishment of agenda and agreement to agenda items at the beginning of the meeting.

- Utilization of consensus-seeking decision-making method when possible.

- Establishment of commonality:

  - identification of roles

  - introduction of each group member

  - identification of meeting purpose

Some reminders for facilitators, to keep the group involved and progressing toward defined goal:

- As the group moves through the agenda, make sure there is agreement at each issue. Each item should be summarized, clarified, and agreed upon before moving to the next agenda item.

- Listen and check for understanding: *"So let me see if I got all the points you were making. It seems that your first priority is _____ and the second most important is _____. Is that right?"*

- Ask open-ended questions: *"Can you tell me more about your plan?"*

- Suggest a variety of processes to keep the group energized and to encourage participation.

- Encourage everyone to participate. (Facilitator notices that one member has been uncharacteristically quiet.): *"Joe, is there anything you'd like to add?"* Whatever the response, be sure to acknowledge.

- Be positive. Demonstrate a "win-win" approach: *"I know this is emotionally difficult, but if we take our time, we can hear from everyone and reach a balanced decision."*

- Summarize and confirm agreements and next steps: *"At this point, we have agreed to #1, #2, and #3. It seems to me that our next step is _____."*

- Educate the group about options and strategy: *"There's no great way to reach an agreement on this. Why don't we take a straw poll and see where each person stands? This is a nonbinding vote, but it will give everyone a chance to voice an opinion and all of us an opportunity to hear where we are as a group."*

- Make the implicit explicit. Say it over again: *"This may sound redundant, but we have just agreed to change the date for our next meeting."*

- Check out assumptions: *"I didn't hear any comments, so I'm assuming that everyone is in agreement."*

Interventions are facilitator behaviors used during a meeting to help get the meeting back on track. Examples of interventions:

- Use congruent body language to reinforce words. Ask for suggestions with an open body language, palms open, arms unfolded.

- Protect others from personal attack. Intervene to stop someone from "railroading" the meeting.

- Use time as a leverage. It is always OK to take a break — it changes the playing field for a short time, helps to relieve tension, and lets group members physically "alter themselves."

- Use time constraints effectively. The heart of issues sometimes surfaces toward the end of a meeting. Remind members of the time frame.

- Model openness and objectivity. Arguing back when given feedback may only escalate the issue. Accept negative feedback and boomerang the issue back to the group member or to the group as a whole: *"Joe, it sounds like you think I'm pushing too hard on this point. Thanks for telling me. How do you suggest that we proceed?"*

- Use humor or stories. Make a joke to relieve tension. Be sensitive not to joke at someone else's expense. Stories can be helpful to make a point, but be sure they are short and outcome-oriented. Be aware you may be unleashing war stores and jokes. Use cautiously!

- Boomerang. Just like in Australia — return a question to the person who asked it or back to the whole group. This helps keep the facilitator from assuming responsibility for group issues and questions.

- Maintain/regain focus. Make sure the team is working on the same issues, at the same time, using the same process: *"I don't think we're focused on identifying problems. Can we get back to identifying problems that have come up since the last meeting?"*

- Say what is going on or when something isn't working: *"It seems that only Joe and Sally are bringing up ideas. What's going on?"*

- Suggest ways to avoid process battles. There are usually a variety of ways for a group to deal with issues and reach agreement. Point out that a number of approaches will work; get agreement to use one. Remind the group there are rarely "right" or "wrong" ways to proceed.

- Enforce process agreements. Remind the group of a previous agreement: *"We agreed to update with new information first, and it sounds like we're brainstorming ideas. Can you hold onto those ideas and let's get back to the update?"* (*The Complete Facilitator Manual: The Interaction Method*, Interaction Associates, Inc.)

11. What are ground rules or standards of behaviors?

Standards of behavior or ground rules are commitments made to one another that are designed to help a group function more effectively. Standards of behavior clarify expectations of each other and are based on sound principles. A group can create its own standards and then reach agreement, or the facilitator can suggest standards and ask the group for agreement. The facilitator should ask the group for feedback on the facilitator's role in enforcing the group's standards. Standards can be added or deleted based on a group's agreement. Possible standards are:

- Share all relevant information.
- Be specific. Use examples.
- Explain the reasons behind all statements, questions, and actions.
- Focus on interests, not positions.
- Stay focused. Discuss a topic long enough for everyone to be clear about it.
- Disagree openly with any member of the group.
- Discuss "indiscussible" issues.
- Don't take cheap shots, distract the group, or have side conversations.
- Share appropriate information with non-group members.
- Make statements, then invite questions.
- Test assumptions and inferences in public.
- Agree on what important words mean.
- Jointly design ways to test disagreements and solutions.
- Ask that all members identify and solve problems.
- Make decisions by consensus-seeking.
- Do self and group critiques. (Schwarz, 1994).

12. How can the facilitator handle conflict and build agreement?

Conflict is inevitable in groups. It is a natural stage of development. Often, groups may shy away from conflictual issues openly because of past differences or cultural influences. The facilitator needs to be aware of cultural influences and prepared to help the group discuss important issues in a safe and productive manner by utilizing smaller discussion groups or offering process alternatives.

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The facilitator's role is to model an "unconditionally constructive strategy" by:

- balancing emotions with reason,
- trying to understand each point of view,
- communicating openly and honestly,
- being reliable and consistent,
- using non-coercive modes of influence,
- demonstrating acceptance and caring, and
- being open to learning from each point of view. (Fisher & Brown, 1989).

Four key words for dealing with difficult situations and people are:

- Accept
- Legitimize
- Deal with
- Defer

By accepting and legitimizing an objection or concern, negativism and resistance can be diffused. There is a reason why a group member may appear to be negative or resistant. Facilitators ask themselves, *"Why is he or she bringing up this issue? Why is this important? What is the intent of the objection?"*

- Listen intently to the person's point. Be able to repeat and summarize the point. Be sure you have captured all points.

- Ask for the person's verification.

- Accept the idea without agreeing or disagreeing.

- Legitimize it by having it recorded.

- Decide as a group if the issue or idea is more appropriate to deal with now or defer to a later point in the agenda (as an add-on) or to another meeting. Make sure that the person who brings up the issue is in agreement with the decision.

  If the group decides to deal with the issue *now* — summarize, clarify, and reach agreement on the issue or prioritization. Return to the agenda where you left off.

- If the group decides to *defer* — it is important that the issue be dealt with. If not, it will continue to haunt the group. The item can be dealt with at the end of the meeting or carried to the next meeting; a special meeting can be convened or a task force established. (Doyle & Straus, 1976).

13. How can a facilitator, planner, or leader prepare to understand and manage cultural differences?

It is critical that facilitators, planners, or leaders demonstrate respect for and understanding of participants' cultural backgrounds. Michael D'Andrea, Ed.D., University of Hawaii, has developed a model for **RESPECTFUL** counseling practice in a pluralistic society. The model is adaptable for use by facilitators and other community planners and leaders. The model is composed of ten variables that can be used to assess the community at large during

the organizing phase of coalition building. The model can also be used personally by facilitators, planners, and leaders to reflect on and address their own cultural influences.

R Religious and Spiritual Orientation
- What are the predominant religious practices in the community?

- As a facilitator, how do my religious/spiritual beliefs influence the planning and management of the meeting?

E Economic Class Standing
- What is the predominant economic status of the community at large, the participants at the meeting, and other stakeholders?

- What values and biases do I carry with me from my own social economic background?

S Sexual Identity and Orientation
- What are the community's espoused values about sexual identity and orientation?

- As a facilitator, how does my sexual identity and orientation influence the meeting?

- Am I genuinely comfortable and confident working with persons with a heterosexual, homosexual, or bisexual lifestyle?

P Psychological Maturity
- How would I describe my own level of psychological maturity at this point in time?

E Ethnic/Cultural/Racial Backgrounds
- What is the dominant ethnic, cultural, and racial makeup of the community? How does this makeup influence issues that the community is facing?

- How do my own cultural biases/preferences influence my work in this community?

C Current Chronological Challenges
- What is the chronological makeup of the community? How does this makeup influence issues facing the community?

- What are the strengths and limitations of my age working in this community?

T Threats to Personal Wellness and Sources of Social Support/Strength
- What are specific stresses facing the community and why are these stresses problematic?

- What are the major sources of support for the community?

- Where do I receive support and guidance for my work?

F Family History and Influence
- How does the community at large identify "family"?

- How has "family" changed over time?

- How has my own family history influenced me?

U Unique Physical Characteristics/Attributes
- What are the community's attitudes about and resources for full accessibility for all residents?

- What are the unique physical characteristics that are sources of pride or stress for the community at large and for individuals at the meeting?

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- What are my own biases regarding a person's unique characteristics and attributes?

L Location of Residence
- What is the impact of the geographical area (rural, suburban, or urban) on the community?

- How do my preferences of residence influence my work?

The role of the facilitator is to maintain a neutrality about issues and a balanced approach to people. Hidden biases can interfere with the facilitator's effectiveness as a "neutral servant" to the group unless she/he explores her/his own cultural influences.

14. How should a meeting be closed?
The final step of a meeting should be to clarify action steps that need to be taken by the next meeting. In its simplest form, an action plan identifies **who** will do **what** by **when** and **how** it will be reported. For example: Joe will present a report on the Senior Citizens Fair at the next meeting on October 15. A visual display may look like:

Who	What	When	How

Finally, the next meeting date, time, and location should be clarified.

15. Should a meeting be evaluated?
Meeting evaluation gives the meeting planners, facilitators, and group members feedback on how the group is performing and can include discussion of how things might be done differently in the future. The simplest evaluation is a facilitated discussion about what was positive about the meeting and what members would like to have changed or enhanced. If there is a suggestion for a change, ask the group member for a suggested alternative.

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Obtaining Funding for Your Community-Based Activities

Background

Communities have good ideas about how they can best serve the needs of their community. Often, however, funding for start-up and evaluation of activities to address these needs is limited. Obtaining external funding for community-based activities can be crucial. Below is a checklist for obtaining external grant support. Following the checklist is an expanded version of the checklist.

1. **Refine your idea.** Clearly state what your objectives are for the project, how you will implement it, and how you will evaluate the program. Write these three things down on paper to further clarify them.

2. **Decide which funding agencies might be appropriate for your project.** Contact the Community Foundation of WNC (14 College Street, Asheville, NC 28801; 704/254-4960) or your local university grants department for help.

3. **Call the contact person for the funding agency.** This is absolutely essential. For this telephone call you will need that brief, one-page outline of the objectives of your program, how you will implement it, how you will evaluate it, and a rough budget.

4. **Use your coalition in writing the grant.**

5. **Revise and expand your program proposal.** Be attentive to the following:

   • Document previously published programs that support the need for your program and show the funding agency that you are aware of other programs on which your proposed program builds.

   • Write a clear objective(s). This is absolutely crucial. Objectives should state what you will specifically accomplish, for whom, by when, and how.

   • How will you implement this program? How is your approach innovative and how will you continue the program after funding ends (sustainability)?

   • Include an evaluation section. This should include not only the number of people who might attend the program, but specific outcomes that would be of interest. For example, the proportion of pregnant women in your program who stopped smoking during their pregnancy as compared to the proportion of women who have stopped smoking who have not used your program (i.e., a comparison or control group).

   • Obtain letters of support from all the various agencies that might be participating or might be interested in the results of your program locally. Ask for these very early in the process of preparing the proposal since they take some weeks to collect.

   • Include a bibliography of similar programs and successes.

6. **Continue to talk with the funding agency while you are preparing the application.**

7. **Include a cover letter that states the importance of your program.**

8. **Call your contact person at the funding agency** about a month after submitting the proposal to check that he or she has received it and to see if any other information is needed.

1. Refine your idea.

- **Write clear objectives.**
  Most communities have not adequately refined their ideas. Someone should be charged with clearly writing the specific objectives for the project. An objective should state exactly what you plan to do, for whom, by when, and the result that you expect. *An example of an objective might be: "By providing smoking cessation counseling to smoking pregnant women in our health department clinics, we plan to reduce the proportion of smoking pregnant women from our current baseline of 25% to 15% in twelve months."* Objectives are difficult to write. Circulate the objectives and have people improve upon them, until all can agree on the objectives. Generally, you will have no more than two or three objectives for any specific program.

- **How will you implement your ideas/program?**
  This might be a specific program that you have designed or revised. Briefly, in two to three sentences, write down how the program will be designed and how it will be implemented. Please note that you cannot assume that your program will be implemented equally at all times and at all sites. Therefore, you have to include a monitoring system to identify times or places during which the program may not be implemented as you had originally planned. Often, one of the major reasons that no changes take place after a program has been implemented is that the program actually was not implemented, and the treatment provided was very similar to the baseline treatment.

- **How will you evaluate the program?**
  We believe that programs we develop will be better than existing programs. However, this may not be true; the degree of difficulty encountered in implementing the program may itself preclude it from being adopted universally. You must develop some objective criteria that identify whether the people using your program are better off after using your program than before using the program. Many new programs may use the status of patients during the time before a program has been implemented, and then compare the results of new patients using the program. This is often easier than some other ways of evaluating the program, but is not as desirable as having a comparison/control group, a group that is not receiving the intervention. For some small communities and small populations within these communities, it may not be practical to have a concurrent control/comparison group that is not receiving the program you wish to evaluate. No matter what the circumstances of your community, evaluation is an integral part of the program, and should be addressed early on during the design of the program.

  Most communities have access, either within their own community or through a local AHEC or university, to people who have evaluation skills. Invite person(s) with evaluation skills to attend your initial meetings to discuss the program you wish to develop. These people will be an invaluable part of the planning team from the very start.

2. Decide which funding agencies might be appropriate for your project.

Local, state, and national agencies/foundations exist, many of which might be appropriate and interested in your project. In Western North Carolina, the Community Foundation of WNC, 14 College Street in Asheville (704/254-4960) maintains a library of agencies and foundations, and their usual funding interests. In addition, all universities have a designated office or division that can provide assistance in identifying the appropriate funding agency(ies). Frequently, universities are willing to run computerized searches that can

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provide community agencies with print-outs of sources of funding for certain types of health programs. *(See Appendix for more information about funding sources.)*

3. Call the contact person for the designated funding agency.

- **Make a good first impression.**
  This is absolutely essential. It is important to make a good first impression and to be willing to talk with the person on the phone. Computerized searches list the program officer/project officer or contact person for each funding agency.

- **Use the one-page outline.**
  For this telephone call, you need a brief one-page outline that includes the objectives of your program, how you plan to implement it, how you plan to evaluate it, a rough idea of the budget, how this program is novel, and especially why this particular agency might find it interesting to fund. The benefit of having this information in front of you is that you can essentially read the information from your outline in an animated way, so that you sound as though you have considered this project and are knowledgeable about how to assess need and how to develop and evaluate programs.

- **Use appropriate terms.**
  Please note that some foundations prefer to fund what we might term "research," a well-accepted study design such as a concurrent comparison group or randomized clinical trial. Other foundations are interested in funding "demonstration programs," and do not like you to use the words "research" or "study." This type of information is available from the description of the funding agency that you received in #2 above.

- **Know approximate amount of money you are requesting from the funding source.**
  Although you may not have specific figures in a budget, it is important to know the average amount of funds awarded by this particular foundation or agency. This will be from the information mentioned in #2. Some agencies and foundations prefer one-year grants, while others have no problem with several years of funding. Depending on the nature of your program, you may be choosing a one-year funding source or a multi-year funding source. In general, it takes a minimum of two years to develop, implement, and evaluate any program.

4. Use your coalition in writing the grant.

Grants written in community versus in isolation result in a better product *and* ensure community ownership of your proposed project. The grant-writing process can be less intimidating and burdensome when coalition members collaborate on the tasks involved. Here is a process developed with the Madison Community Health Consortium to share the workload:

- Develop a centralized, computerized database including a community description and a summary of health indicators for your community. This can serve as a "boiler plate" that can be adapted for a variety of types of grant proposals. This data can also be furnished to member agencies, as needed, for their independent grant efforts.

- When considering grant opportunities (sometimes called Requests for Proposals) that relate to your coalition's goals, include the membership in brainstorming the contents for the grant application. Record their ideas on flip chart sheets where the group can view them together.

- If your coalition is not incorporated, decide which member organization should be the grant applicant. Decide who will type the final proposal and which letterhead is needed.

- Determine letters of support or other support documents needed and request these from the member organizations. Assign members to obtain letters needed from non-member organizations.

- Appoint a 3- or 4-person "writing/editing" team to consolidate the coalition's recommendations and draft a proposal. We find sitting together around the computer with one person typing to be more efficient than meeting over pen and paper, and then typing later.

- Appoint an appropriate member to inform and obtain the endorsement of key "power brokers" in the county (Commissioners, Board of Education, etc.).

- Appoint a committee to develop the budget, if required for the proposal.

- Hold an "editing" meeting for the full membership to read, edit, and comment upon the first draft.

- The applying agency can submit the final proposal to the granting agency.

- Debrief with the coalition after the award announcement. If the grant was not funded, the coalition should discuss what lessons were learned and how to approach other funding sources.

5. Revise and expand your program proposal.

This assumes that you find a funding agency that is interested in seeing an expanded proposal. During your conversation with the contact person, you might have found a particular area of interest that you would need to highlight in your proposal to them. Make sure that you address how your program specifically will enhance the goals of the foundation or agency.

- You need to *perform a literature search*, documenting previously published programs that would support the need for your program, and showing the funding agency that you are aware of other programs on which your proposed program builds. This does not need to be long, usually no more than two or three paragraphs, but is necessary to demonstrate that you are not designing a program that has already been found to be useful, or to be of no use. Foundations often want to fund programs that are likely to be suitable for replication in other places, so they need to believe that you might be able to generalize your findings.

- *Write clear objectives*. This is absolutely crucial. As stated above, these objectives will reflect what you expect to accomplish, for whom, by when, and how. Be clear about how you will implement this program, how your approach is innovative, and how you will continue the program after funding ends.

- *Sustainability*, as foundations call this, is another crucial item. Foundations do not like to fund a program that will dissolve after external grant support ends. In your proposal, you need to specifically address where funds will be obtained to continue the program, presuming it will be successful. If you do not have a specific idea as to where you will get funds to continue this program once external funding is completed, you can develop a plan to identify sources of funds for the continuation of your project. This is often an acceptable alternative.

- You must *include an evaluation section*. In addition, we highly recommend that you have an identified person, either a member of your staff or a consultant who is considered an evaluation expert. The evaluation section should include not only the number of people you anticipate attending/using the program, but specific outcomes of interest. These outcomes of interest need to be measurable — that is, you need to be able to enumerate numbers of people who use the services and who have the desired outcome. Ideally, you would have a comparison or control group where you can enumerate the people who have not had access to the program and their outcomes.

- *Obtain letters of support* from all the agencies that might be participating or who might be interested in the results of your program. Ask for these very early in the process of preparing the proposal, since they take some weeks to collect. We also recommend that you provide them with a draft letter that they can adapt for this purpose. These letters of support are extremely important, and should specify how each of the organizations will participate in the program development and evaluation, or how they might use the information that you collect. These draft letters therefore should be personalized for each agency from which you are requesting the letter of support.

- *Include a bibliography*. This bibliography should contain the citations from your literature search identifying similar programs and successes or failures of these programs.

- *Budget*. Foundations and granting agencies like a dedicated staff person who will be able to devote almost all of his or her time to overseeing the development and implementation of this program. Make certain that you include adequate funds for evaluation.

5. Continue to talk with the funding agency while you are preparing the application.

As you write your proposal, questions will emerge. Accumulate these questions and call your contact person at the funding agency. You do not want to be a bother by calling each week. However, one or two additional calls after the first contact would be helpful in terms of identifying whether or not your proposal would meet the agency's needs and allowing some personal feedback before you commit yourself on paper.

6. Include a cover letter that states the importance of your program.

Although you clearly state the importance of your program in the body of the proposal, you do need to state in the cover letter to the funding organization why this program will be important for your community, for the region, and possibly for the nation, and how your program enhances and allows the funding organization to reach its goals.

7. Call your contact person at the funding agency a month after submitting the proposal.

It is highly unlikely that the proposal will be lost in the mail; it is more likely that once the proposal reaches the funding agency, it may be sent to the wrong person and/or be misplaced. We have had personal experience with proposals being lost within a funding organization. Many agencies will have you include a postcard that they return to you, confirming that the proposal has been received. However, it is a good idea to call your contact person at the end of the month to ensure that they have received your proposal, and that they have reviewed its contents briefly to determine if there is any missing information.

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APPENDIX

Sample Membership Survey

Foundations for Health Project Funding

Additional Sources of Funding Information

AHEC/Community Partners Tip Sheets

Madison Community Health Consortium
Membership Survey

I commit to membership in the MCHC and choose to serve as (*Please circle membership code below and check related items as appropriate*):

M = **MEETINGS PARTICIPANT:** I will participate in group decision making through attending, or sending a representative, to (**Check all that apply**):
a._____ Plenary MCHC Meetings (every two months)
b._____ MCHC Committee Meetings (monthly or as needed)
If b checked, check the committee(s) you wish to remain on/join:
_____ Physical Fitness Council (promote fitness for all ages)
_____ Substance Abuse Task Force (prevention for adolescents and pregnant women)
_____ Resource Committee (long-range planning/funding)
_____ Elderly Health/Senior Fair
_____ Injury Prevention/911
_____ Listening to Children Partnership (Children birth to five)
(**overlaps with MCHC membership**)

R = **RESOURCE PERSON:** I cannot attend meetings but would like to remain on the MCHC mailing list and (**check all that apply**).
a._____ I will share MCHC information (flyers/posters) with my staff/clients/community.
b._____ I want to be contacted about helping with special events, such as health fairs or community walks.

O = **OTHER** ways I can contribute (**describe**):
_____
_____

Signature: _____

~~~~~~

C = I **CANNOT** remain involved in the MCHC. Please remove my name from the mailing list.

Name: _____

Title: _____

Agency/Organization: _____

Comments/Suggestions:

THANKS!!!

Return to June Trevor, Madison Community Health Project, Hot Springs Health Program, P.O. Box 909, Mars Hill, NC 28754.

Foundations for Health Project Funding

Some local, regional, and national foundations indicate in their annual reports and/or application guidelines that health care issues are a priority or a major interest. The following table is a list of some of the major resources for monitoring foundations and their current interests. Each of these guides provides information about foundations' history, interests, funds available, application guidelines, geographic preferences, types of support.

Grantseekers in Buncombe County, North Carolina, are fortunate to have the Community Foundation of Western North Carolina, which houses a grant resources library. The following publications plus a number of others are available to the public at the Community Foundation's office. Community foundations in other locations may have this same service. Public or university libraries may well have some or all of these funding resources.

The Foundation Directory and Foundation Directory, Part 2

The Directory lists the nation's largest grantmaking foundations with assets of $1 million or more or which have annual giving of at least $100,000. It has geographic, subject, foundation names, type of support, new foundation indices. Part 2 focuses on foundations with assets of less than $1 million and annual grantmaking between $25,000 and $100,000. Up to ten sample grants for each foundation are provided, which indicate giving interests and geographic preferences. These directories are published yearly; 1995 is the most current one available. A supplement is published six months later.

North Carolina Giving

A guide to the state's foundations includes subject/areas of interest. Published every three years. Latest edition is 1993.

A Grantseeker's Guide to Funders in Central Appalachia and the Tennessee Valley

Published by the Appalachian Community Fund, this directory contains 429 entries including listings of foundations in the region, funders outside the region, revolving loan funds, religious funders, Japanese funders active in the region. Most recent publication is 1993 with a six-month later supplement.

FOUNDATIONS FOR HEALTH PROJECT FUNDING

Foundation Name	Areas of Interest/Preference	Geographical Restrictions	Other Restrictions	Average Award/ Duration of Award	Contact Person
ABBOTT LABORATORIES FUND	Includes: medical school/education, hospitals (general), pharmacology, nursing care, health care, health orgs., medical research, human services Type: operating budgets, continuing support, research	Primarily in areas of company operations	No funding for deficit financing, land acquisition, publications, social organizations, individuals	Average $2,000-$25,000	Kenneth W. Farmer, Pres. Dept. 379, Bldg. 6C One Abbott Park Rd. North Chicago, IL 60064 (708)937-7075, (708)937-8686
AETNA FOUNDATION,INC.	Health care, education, minorities. Priority areas are immunization and health care for children. Type: seed money, special projects	Hartford, CT area and other areas of company operations	No grants for medical research, capital/building funds, renovations, annual operating funds, computer hardware	Average $5,000-$25,000	Diana Kinosh Mgt. Info. Supervisor 151 Farmington Ave., RE1B Hartford, CT 06156 (203)273-6382
APPALACHIAN COMMUNITY FUND	Progressive community change in central Appalachian states including developing community-based affordable and accessible health care in rural areas	Appalachian counties of KY,WV,VA,TN	No direct services unless tied to social change programs. None to major capital projects or those heavily foundation or government financed	Maximum $7,500 in one year Single year and two-year grants	Mary Bryan 517 Union Ave, Suite 206 Knoxville,TN 37902 (615)523-5783
BLUMENTHAL FOUNDATION	Social services, education, arts and humanities, health care, environment Type: Building funds, equipment, operating budgets, emergency funds, research, general purposes publications, confs. & seminars, seed money, special projects	Primarily in NC, with emphasis on Charlotte	None to individuals	Average $100-$25,000	Philip Blumenthal, Trustee PO Box 34689 Charlotte,NC 28234 (704)377-6555
BROYHILL FAMILY FOUNDATION	Child development services, education, health care, health orgs., human services, children & youth services Type: Program development, scholarship funds	Primarily in NC	None to individuals	Average $8,704	Paul Broyhill or Mrs. Lee E. Pritchard PO Box 500, Golfview Park Lenoir, NC 28645 (704)758-6120

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Foundation Name	Areas of Interest/Preference	Geographical Restrictions	Other Restrictions	Average Award/ Duration of Award	Contact Person
KATHLEEN PRICE AND JOSEPH M. BRYAN FAMILY FOUNDATION	Education, arts, health and human services, including AIDS programs, public interest, and youth. Type: General/operating support, continuing support, building/renovation, equipment, endowment funds, program development, seed money, tech. assistance	Limited to NC, with emphasis on Greensboro, Guilford County and rural areas	None to conferences, individuals, annual fund drive, research, film or video production	Average $5,000-$100,000	William Massey, Exec. Dir. One North Pointe, Suite 170 3101 North Elm Street Greensboro, NC 27408 (910) 288-5455
BURLINGTON INDUSTRIES FOUNDATION	Higher ed., hospitals, health care, health organizations; human services; children & youth, services; hospices, community development Type: Annual campaigns, capital campaigns, building/renovations	Primarily in areas of company operations in NC, SC, and VA.	None to individuals, conferences, seminars, workshops, endowments, medical research operating expenses	Average $100-$5,000	Park R. Davidson, Exec. Dir. Box 21207 3330 West Friendly Avenue Greensboro, NC 27420 (910)379-2515
BURROUGHS WELLCOME FUND	Medical ed., research, biological sciences, medical sciences, pharmacy Type: Research, scholarships, fellowships, education grants, visiting professorships.	None stated	None to individuals, operating budgets, continuing support, publications, conferences	Average $1,000-$50,000	Martha G. Peck, Exec. Dir. 4709 Creekstone Drive, Suite 100 Morrisville, NC 27560 (919)991-5100
CANNON FOUNDATION	Health care and higher education Type: Capital improvements or special purposes other than operational uses	Primarily in NC, especially in the Cabarrus County area	None for endowments, scholarships, fellowships	High $1,000,000 Low $1,000	Dan L. Gray, Exec. Dir. P.O. Box 548 Concord, NC 28026 (704)786-8216
CITICORP CORPORATE CONTRIBUTIONS PROGRAM	Health & human service, higher ed., arts ed. & culture, community development. Focus on community-based health care programs, particularly the needs of children.	None stated	None to individuals, political efforts, fundraising events, advertising	NA	Paul Ostergard, Vice President Dir., Corp. Contributions & Civic Responsibility 850 Third Avenue, 13th floor, Zone 10 New York, NY 10043 (212)559-5358

Foundation Name	Areas of Interest/Preference	Geographical Restrictions	Other Restrictions	Average Award/ Duration of Award	Contact Person
CLOSE FOUNDATION	Early childhood education and health services Type: general purposes, seed money, conferences, seminars, building & renovation, matching funds	Primarily in Lancaster county, Chester Township of Chester County, and Fort Mill Township, SC, and NC	None stated	Average $400-$225,000	Charles Bundy, Pres. PO Drawer 460 Lancaster, SC 29721 (803)286-2196
COMMONWEALTH FUND	Improving health care services, advancing the well-being of elderly people, developing the capacities of young people, promoting healthier lifestyles, bettering the health of minorities. Type: Research, special projects	None Stated	Building, endowments, general support, capital funds, construction or renovation, operating budgets	Average $5,000-$40,000	Adrienne A. Fisher, Grants Mgr. One East 75th Street New York, NY 10021 (212)535-0400
COMMUNITY FOUNDATION OF WESTERN NC	Social services, youth, arts, education, environment, health Type: Matching funds, seed money, scholarship funds, tech. assistance, special projects	Western NC	Capital campaigns, endowments fundraising activities, debt retirement, general operating support	Average $50-$50,000 One year grants	Pat Smith, Exec. Dir. PO Box 1888 Asheville, NC 28802 (704)254-4960
DONALD AND ELIZABETH COOKE FOUNDATION	Education, legal ed., health care, general charitable giving Type: continuing support, seed money, general purposes, building & renovation	Primarily in NC	None stated	High $30,000 Low $400	Harry Fullenwider or Sandy Patterson 235 East Penn. Ave. Southern Pines,NC 28787 (919)692-7811
COOPER INDUSTRIES FOUNDATION	Health care, substance abuse services, cancer, health organizations, cancer research, AIDS research, youth services, community development Type: general/operating support, continuing support, annual/capital campaigns, building/renovation, emergency funds, program development, seed money	Primarily in areas where Cooper (Bussmann) has plants and concentrations of employees	None to national or state health & welfare organizations. None to individuals, endowments, publications, conferences/seminars, or generally for hospital capital fund drives or their operating campaigns	Average $1,000-$5,000	Viriginia O. Wieler, Asst. Secretary PO Box 4446 Houston, TX 77210 (713)739-5632

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Foundation Name	Areas of Interest/Preference	Geographical Restrictions	Other Restrictions	Average Award/ Duration of Award	Contact Person
C P & L FOUNDATION	Includes: Education, community funds, community development, civic affairs, arts, cultural programs, health associations, social services, environment, conservation Type: General/operating support, special projects, annual/capital campaigns, endowments, general purposes, confs./seminars equipment	Primarily in NC and small service area in SC	None to individuals, organizations duplicating work done by United Way member agencies supported by the company	Average $6,000-$20,000	Barbara K. Allen, Asst. Secy. or Jan P. Henderson, Contribs. Coord. P.O. Box 2591 Raleigh, NC 27602 (919)546-6309 (919)546-6441
NATHAN CUMMINGS FOUNDATION, INC.	Includes: health care, health organizations, human services. Improving the health delivery system for the poor Type: General/operating support, annual/capital campaigns, building/renovation, program development, confs/seminars, seed money, consulting services	Within the US	None stated	Average $10,000-$75,000	Charles R. Halpern, Pres. 1926 Broadway, Suite 600 New York,NY 10023 (212)787-7300
HARRY L. DALTON FOUNDATION	Includes family planning; substance abuse, services; mental health/crisis services; alcoholism; youth, services; community development Type: capital campaigns, building/renovation, endowment funds	Primarily in NC	No grants to individuals	High $43,100 Low $$25 Both single and multiple-year grants	R. Alfred Brand, III, VP 736 Wachovia Center Charlotte, NC 28285 (704)332-5380
ADELAIDE WORTH DANIELS FOUNDATION, INC.	Higher ed., health care, health services, child welfare Type: Capital campaigns, scholarship funds	Primarily in Western NC	None stated	NA	A. Daniels Key, Pres. 35 Peach Know Drive Asheville, NC 28804
LUCY DANIELS FOUNDATION, INC.	Psychology, psychiatry, arts Type: Conferences and seminars grants to individuals, research	Focus on NC, esp. Raleigh-Durham-Chapel Hill area	None stated	NA	Lucy D. Inman, Chair 9001 West Pkwy Cary,NC 27513 (919)677-9888

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Foundation Name	Areas of Interest/Preference	Geographical Restrictions	Other Restrictions	Average Award/ Duration of Award	Contact Person
DICKSON FOUNDATION,INC.	Includes: education, association; higher ed.; hospitals (general); human services; youth, services Type: general/operating support; scholarship funds	Primarily in NC	No grants to individuals, building, endowment funds	Average $3,447	Alan T. Dickson 2000 Two First Union Center Charlotte, NC 28282 (704)372-5404
DOVER FOUNDATION, INC.	Includes higher ed.; health care; human services Type: general operating support, annual/capital campaigns, building/renovation, scholarship funds	Primarily in NC	None stated	Average $100-$200,000	Hoyt O. Bailey, President PO Box 208 Shelby, NC 28151 (704)487-8890
DUKE ENDOWMENT	Higher ed., health care, child care, religion Type: general support, seed money, special projects, equipment, materials, research, publications, confs.& seminars, consulting services, tech. assistance, general purposes	NC and SC	None to individuals	High $16,480,844 Low $281	Jere W. Witherspoon, Exec. Dir. 200 South Tryon Street Charlotte, NC 28202 (704)376-0291
DUKE POWER COMPANY FOUNDATION	Includes health care; health orgs.; safety/disasters; human services; hospices; homeless, human services Type: general/operating support, capital campaigns,	NC and SC	None to hospitals, supported by Duke Endowment, to individuals or to projects where foundation would be only donor	Average $500-$10,000	Selby D. Kornegay, Jr., Veep 422 South Church Street, Charlotte, NC 28242 (704)373-7039
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
EDUCATIONAL FOUNDATION OF AMERICA	Includes: family planning, cancer, cancer research, reproductive rights, transportation, peace, Native Americans Type: program development, seed money, matching funds	Within US	None to individuals, capital funds, endowments	Average $10,000- $150,000	Diane M. Allison Executive Director 35 Church Lane Westport, CT 06880 (203)226-6498

Organization	Focus / Type	Geographic	Restrictions	Average	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities. Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs, Eaton Center, Cleveland, OH 44114, (216)523-4822
EXXON EDUCATION FOUNDATION	Health focus includes medical & health ed., health-care delivery, environmental health & substance abuse. Type: General purposes, special projects	None stated	None to individuals, capital or building funds, renovations, equipment	Average $5,000-$50,000	E.F. Ahnert, Exec. Dir. 225 East John W. Carpenter Freeway, Irving, TX 75062, (214)444-1104
FIRST UNION FOUNDATION	Community dev., social service, health, education, cultural programs, arts, hospital (building funds), housing. Type: building funds, capital campaign, endowments, operating budgets, renovations, special projects, seed money, general purposes.	Limited to DC,FL,GA,MD,NC, SC,TN,VA	No grants to individuals, retirement homes, organizations supported through United Way	Average $100-$20,000	Ann D. Thomas, Dir. Corporate Contributions, Two First Union, Charlotte, NC 28288, (704)374-2973
FULLERTON FOUNDATION, INC.	Hospitals, health care, medical research, education. Type: special projects, matching funds, seed money	Primarily in NC and SC	None to individuals	Average $10,000-$60,000	Walther E. Cavell, Executive Director, PO Box 1146, Gaffney, SC 29342, (803) 489-6678
GERBER COMPANIES FOUNDATION	Includes: medical ed.; health care; hospitals; nursing; hospices; health services; nutrition; medical research. Type: Op. budget, continuing support, annual campaigns, building funds, matching funds, confs. & seminars, equipment	Limited to cities of company operations in AR,CA,IN,MI,NY, NC,SC,TN & WI	None for seed money, emergency funds, demonstration projects, publications	Average $500-$5,000	Grace J. Deur, Secy., or Barbara J. Ivens, Pres. 445 State Street, Fremont, MI 49413, (616) 928-2759
JAMES G. HANES MEMORIAL FUND	Health, cultural programs, conservation, community development, arts. Type: annual campaigns, seed money, emergency funds, buildings, equipment, land acquisition, matching funds, special projects, research, publications, endowment funds	Primarily in NC & Southeast	None to individuals or general operations or maintenance	Average $1,000-$25,000	Manager, Foundations/Endowment, c/o Nations Bank, One NCNB Plaza T09-1, Charlotte, NC 28255, (704)386-8477

Name	Type/Interests	Geographic Area	Restrictions	Amount	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
JOHN A. HARTFORD FOUNDATION, INC.	Includes: Aging and health program; health care cost and quality; community health reform, community health mgt. info. system Type: op. budget, continuing support, program development, special project.. research, publications, confs & seminars	Nationwide	None to individuals, annual/capital campaigns, seed money, emergency, endowments	Average $50,000-$300,000 Grants rarely provided for more than three years	Richard Sharpe Program Director 55 East 59th Street New York, NY 10022 (212)832-7788
HASKELL FUND	Includes: hospitals, health agencies, family planning, environment Type: Annual campaigns, building funds, continuing support endowments, general purposes, op. budgets, special projects, scholarships	None Stated	None to individuals	Average $1,000-$5,000	Donald C. Cook, Treasurer 1010 Hanna Building Cleveland, OH 44115 (216)696-5528
J.M. FOUNDATION	Rehabilitation of physically handicapped, prevention and wellness emphasizing individual responsibility for health, prevention and early intervention in alcohol and other drug abuse, health-related public policy research, biomedical research and medical education Type: research, special projects, publications, internships, scholarship funds, matching funds, confs.& seminars, tech. assist, seed money	None Stated	No support for arts. None to individuals, operating expenses, fundraising, capital campaigns, endowments	Average $15,000-$35,000	Chris K. Olander Executive Director 60 East 42nd Street, Room 1651 New York, NY 10165 (212)687-7735
JANIRVE FOUNDATION	Higher ed.; hospitals (general); health assocs.; housing/shelter; development; human services; children & youth, services; family services; community development; general charitable giving Type: general operating support	Primarily in NC	None to individuals, operating budgets, endowments	Average $10,000-$50,000 Prefers single-year grants	Met R. Poston, Chair PO Box 2450 Asheville, NC 28802 (704)258-1877

		Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects				
ROBERT WOOD JOHNSON FOUNDATION	1.Assuring access to basic health services. 2.Improving the way services are organized & provided for chronic health conditions 3.Promoting health and preventing disease by reducing harm from substance abuse 4. Health care cost Type: seed money, research, special projects, fellowships, program-related investments	Within the US	None to individuals, general operating expenses, endowments, capital costs, conferences or symposia, publications or media	NA	Edward H. Robbins Proposal Manager PO Box 2316 Princeton, NJ 08543 (609) 452-8701
HENRY J. KAISER FAMILY FOUNDATION	Health, AIDS, family planning, disadvantaged, minorities Type: Special projts, research, seed moeny, fellowships, confs/seminars, publciations, matching funds, tech. asstistance		None to individuals, constructions, equipment, capital funds, general op. expenses, indirect costs	Average $25,000- $250,000	Renee Wells Grants Mgr. c/o Quadrus 2400 Sand HIll Road Menlo Park, CA 94025 (415) 94025
W.K. KELLOGG FOUNDATION	Improve human well-being in areas of youth, higher ed., leadership, community based health services, food systems, rural development Type: Seed money, fellowships	Nationwide	None to individuals, building, endowments, research, equipment, publications confs., media	$75,000- $250,000	Nancy A. Sims Executive Assistant One Michigan Avenue Battle Creek MI 49017 (616) 968-1611
J.W. KIECKHEFER FOUNDATION	Medical research, hospices and health agencies, social services, youth and child welfare, conservation, community funds, cultural programs Type: op. budget, continuing support, annual campaigns, emergency funds, building, equipment, land, endowment funds, matching funds, research publications, confs. and seminars, special projects	None stated	None to individuals, seed money, scholarships, fellowships, demonstration projects	Average $1,000-$10,000	Eugene P. Polk, Trustee 116 East Gurley Street PO Box 750 Prescott, AZ 86302 (602)445-4010

Organization	Purpose / Type	Geographic	Restrictions	Grant Amount	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities. Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
KRESGE FOUNDATION	Challenge grants for building constr. or renovation, major capital equipment, purchase of real estate	None stated	None to individuals, operating, special project budgets, conferences, seminars, endowments, fellowships scholarships, research	High $2,250,000 Low $25,000	Alfred H. Taylor, Jr., Chair PO Box 3151 3215 W. Big Beaver Rd. Troy, MI 48007 (313)643-9630
MELVIN R. LANE CHARITABLE TRUST	Social services, especially those orgs. dealing with needs of the elderly, physically, mentally, or emotionally disabled. Type: Seed money, matching funds, op. purposes, special projects	Primarily in WNC	None to individuals, endowments, political organizations.	Average $11,170	Martha B. Carlisle Charitable Funds Group c/o Wachovia Bank and Trust PO Box 3099 Winston-Salem, NC 27150 (919)770-5289
LOWE'S CHARITABLE AND EDUCATIONAL FOUNDATION	Education, health care, social services. Also arts, environment, minority issues, media. Type: Special projects, gen. purposes, continuing support, building funds	Majority given in NC	Only to qualified charitable or educational institutions	Average $1,186 Both single and multiple-year grants	Petro Kulynych, Chair PO Box 1111 North Wilkesboro, NC 28656 (919)651-4200
JOSIAH MACY, JR. FOUNDATION	Medical school/education; health care; reproductive rights; African Americans; Latinos; Native Americans; women; economically disadvantaged Type: Program development; confs./seminars; publication; curriculum development	None stated	None to individuals, travel, capital, endowments, operating budget, annual fund, seed money, emergency funds, research publications scholarships/fellowships	Average $20,000- $200,000	Thomas H. Meikle, Jr, MD, Pres. 44 East 64th Street New York, NY 10021 (212)486-2424
MARCH OF DIMES FOUNDATION	To improve health of babies by preventing birth defects and infant mortality. Type: research, community services, education, advocacy	None stated			1275 Mamaroneck Avenue White Plains, NY 10605

Organization	Purpose	Geographic	Restrictions	Amount	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
JAMES G.K. MCCLURE EDUCATIONAL & DEVELOPMENT FUND	Education, nursing, rural development, minority ed., literacy, community development, youth Type: Scholarship, building, student aid, exchange programs, general purposes	Limited to WNC	None to individuals, endowments	Average $1,000-$5,000	John Curtis Ager Executive Director Sugar Hollow Farm 11 Sugar Hollow Lane Fairview, NC 28730 (704)628-1044
METROPOLITAN LIFE FOUNDATION	Includes: health care, nursing care; substance abuse, services; AIDS; alcoholism; health organizations; AIDS research; women, center & services; minorities/immigrants Type: general/ op. support, continuing support, program development; publication; seed money; scholarship funds; research	None Stated	None to organizations primarily engaged in patient care or direct treatment, drug treatment centers and community health clinics, hospital capital fund campaigns, endowments	Average $1,000-$150,000	Sibyl C. Jacobson President and CEO One Madison Avenue New York, NY 10010 (212)578-6272
MILLS FAMILY FOUNDATION	Emphasis on health care and social services	Majority in Western NC	None to individuals	Average $799	Pamela Turner P.O. Box 8100 Asheville, NC 28814 (704)645-3061
RUTH MOTT FUND	Includes: health promotion with emphasis on preventive programs for low-income sectors of the population that emphasize: improved nutrition, stress control, exercise and fitness, smoking cessation, and reduced alcohol and drug use. Also, access and equity concerns for low-income people Type: General/operating support, continuing support, program development, confs./seminars, publications, seed money, tech. assistance	Nationwide	None to individuals, capital or endowment funds, annual campaigns emergency funds, major equipment, renovations, films and videos	Average $15,000-$25,000	Deborah E. Tuck, Exec. Dir. 1726 Genesee Towers Flint, MI 48502 (810)232-3180

Organization	Interests / Type	Geographic	Restrictions	Average Grant	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
NEW-LAND FOUNDATION, INC	Mental health, minority and medical education, social services, youth, environment, public interest Type: General purposes, annual campaigns, seed money, research, continuing support, internships, matching funds, operating budgets, special projects	None Stated	None to individuals	NA	Robert Wolf, President 1345 Avenue of the Americas, 4th Floor New York, NY 10105 (212)841-6000
NEW WORLD FOUNDATION	Raise standards for public and personal health & enhance communities' and peoples' capacity to achieve them. Type: special projects, confs., seminars, program-related investments, tech. assist, seed money, loans.	None Stated	No community fund drives, schools, hospitals. None to individuals or general operations, continuing support, capital building or endowment, research no action-or policy oriented	Average $1,0000-$25,000	Colin Greer, President 100 East 85th Street New York, NY 10028 (212)249-1023
NORTON COMPANY FOUNDATION	Health & human services; education; culture & the arts, civic & community activities Type: Program-related investments, op. budgets, annual campaigns, seed money, building funds, matching funds, continuing support, general purposes, special projects.	Primarily in areas of company operations	No national organizations. None to individs, endowments, scholarships, fellowships	Average $1,000-$10,000	Francis J. Doherty, Jr., Secretary 1 New Bond Street P.O. Box 15008 Worcester, MA 01608 (508)795-4700

EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
DAVID AND LUCILE PACKARD FOUNDATION	Center for the Future of Children to help low-income women have healthier babies, and improve child development and the effectiveness of medical interventions on young children Type: General purposes, building, land, equipment, research, matching funds, program-related investments, consulting services, tech. asst., op budgets, capital campaigns, seed money, special projects	None Stated	None to individuals, endowments	Average $2,000-$50,000	Colburn S. Wilbur Executive Director 300 Second Street, Suite 200 Los Altos, CA 94022 (415)948-7658
PETERSON FAMILY FOUNDATION,INC	Includes: education; hospitals(general); human services; youth, services; community development Type: continuing support, annual campaigns, seed money, general purposes, building & renovation, special endowments	Primarily in NC	None to individuals	Average $2,000-$10,000	Robert Peterson, Pres. Nine Baird Mountain Road, East Asheville, NC 28804 (704)298-0972
PEW CHARITABLE TRUSTS	Health focus: (1) To strengthen the ability of academic health centers and other ed. institutions to train health practitioners to be more responsive to the changing needs of the American public. (2) To promote improved birth outcomes. Type: Seed money, matching funds, continuing support, building & reno, equipment research op. budgets, special projects, capital campaigns, gen. purposes internships, tech. asst., confs.& seminars	None Stated	None to individuals, endowments, scholarships	NA	Rebecca W Rimel, President Three Parkway, Suite 501 Philadelphia, PA 19102 (215)568-3330

EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
LYNN R. AND KARL E. PRICKETT FUND	General charitable giving with interest in health care Type: General, operating support	None Stated	None stated	High $70,000 Low $2,000	C.W. Cheek PO Box 20124 Greensboro, NC 27420 (919)274-5471
PRUDENTIAL FOUNDATION	Health care focus: Community-based programs that provide high-quality, cost-effective health care & human services to disadvantaged families. Capacity building & general support to local HIV/AIDS service orgs., Community-based programs that enhance health care or human services professionals' sensitivity to the needs of minority ethnic or racial groups, development of policy analysis that addresses critical public health needs. Type: Equipment, program development, confs/seminars, seed money, tech assist. consulting services	Primarily in areas of company operations, esp. Newark, NJ, CA, FL, MN, PA	General operating funds, individuals, endowments	Average $10,000-$75,000	Barbara L. Halaburda, Secy. Prudential Plaza 751 Broad Street Newark, NY 07102 (201)802-7354
QUAKER OATS FOUNDATION	Social services, higher ed., civic affairs, community funds, youth, hospitals, arts, cultural programs. Type: general purposes , building, equipment, land, op. budgets, special projects, matching funds, annual campaigns, publications, confs., seminars, continuing support	Primarily in areas of company operations, particularly IL.	None to individuals	General range $1,000-$10,000	W. Thomas Phillips, Secretary Quaker Tower 321 North Clark Street Chicago, IL 60610 (312)222-7033

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Organization	Purpose/Type	Geographic	Restrictions	Range	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
KATE B. REYNOLDS CHARITABLE TRUST	Increase availability of health services to underserved; address problems of health services in rural areas; reduce rate of infant mortality/morbidity; promote good health and prevent illness Type: op.budgets, continuing support, annual campaigns, seed money, matching funds, capital campaigns, equipment, general purposes, renovation, special projects	Limited to NC	None to individuals, endowment, medical research	Average $20,000-$200,000	E. Ray Cope, Executive Director 128 Reynolda Road Winston-Salem, NC 27106 (919)723-1456
ROCKWELL INTERNATIONAL CORPORATION TRUST	Higher education primarily engineering ed. Also, cultural programs, health, and human services Type: op. budgets, building funds, scholarship funds, fellowships, professorships	Primarily in areas of corporate operations	None to individuals, hospital building campaigns, general endowments	General range $1,000-$50,000	William R. Fitz, Secy. Contributions and Community Relations 625 Liberty Avenue Pittsburgh, PA 15222 (412)565-5803
ROYAL INSURANCE FOUNDATION, INC.	Education, health services, social services, arts, civil affairs, general charitable giving Type: Annual campaigns, in-kind gifts, scholarships, fellowships, internships, matching funds, capital campaign, op. budgets, special projects, equipment	Primarily in NE, SE and Midwest	None to individuals, medical research, endowments	High $93,000 Low $100	Linda J. Holland 9300 Arrowpoint Blvd. P.O. Box 1000 Charlotte, NC 28201
SQUARE D FOUNDATION	Community funds, education, health services, cultural programs Type: building funds, operating budgets, professorships, scholarships, capital campaigns	Primarily in areas of company operations: NC,SC, IA, FL, OH, IL, IN, TN, AL, KY, NE, WI, MO TX, and CA	None to United Way agencies, religious, political,labor. None to individuals	General range $500-$5,000	Charles E. Hutchinson, Secretary Executive Plaza Palatine, IL 60067 (708)397-2600

Organization	Areas of Support	Geographic	Limitations	Average Grant	Contact
EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
STEELCASE FOUNDATION	Social services, health, handicapped, AIDS, youth, aged, disadvantaged, community development, environment	In areas of company operations	None to individuals, conferences & seminars, endowments	Average $2,000-$25,000	Kate Pew Wolters, Exec. Dir. Location CH.5C PO Box 1967 Grand Rapids, MI 49501 (616)246-4695
TEXTRON CHARITABLE TRUST	Community funds, higher ed., hospitals and health agencies, youth, urban programs, minorities, cultural programs Type: Building funds, equipment, matching funds, tech.asst. capital campaigns, general purposes, special projects	Primarily in areas of company operations	None to individuals, endowments, land acquisition, demonstration projects	Average $1,000-$20,000 Primarily single-year commitments	Elizabeth W. Monahan Contributions Coordinator PO Box 878 Providence, RI 02901 (401)457-2430
UNION CAMP CHARITABLE TRUST	Community funds, education, hospitals and health services, social services, youth and women Type: op. budgets, continuing support, annual campaigns, buildings funds,renovations,equipment special projects, research, matching funds seed money	Primarily in areas of company operations	None to individuals	Average $25-$2,500	Sydney N. Phin, Director Human Resources c/o Union Camp Corp. 1600 Valley Road Wayne, NJ 07470 (201) 628-2248
PHILIP L. VAN EVERY FOUNDATION	Social services, health and medical research, education	Primarily in NC, SC	None Stated	Average $5,000-$20,000	Zean Jamison, Exec. Dir. c/o Lance Inc., P.O. Box 32368 Charlotte, NC 28232 (704)554-1421

EATON CHARITABLE FUND	Health, human services, medical research, health care facilities Type: general operation, capital grants, special projects	Primarily in areas of company operations	None to individuals, organizations which could be part of a united fund but chose not to	Average $1,000-10,000	Frederick B. Unger, Dir. Comm. Affairs Eaton Center Cleveland, OH 44114 (216)523-4822
WINN-DIXIE STORES FOUNDATION	Hospitals, higher ed., community funds, youth, social services, civic affairs Type: Annual campaigns, buildings funds, equipment, matching funds, research special projects, confs.& seminars, continuing support	Primarily in areas of company operations	None to individuals	Average $100-$5,000	L.H. May, President 5050 Edgewood Court Jacksonville, FL 32205 (904)783-5000
WINSTON-SALEM FOUNDATION	Social services, health, arts, civic affairs, education, youth, aged, community development, drug abuse Type: Seed money, emergency funds, student aid, special projects, matching funds, general purposes, continuing support, tech. asst.	Primarily Forsyth County, NC area, some support in Northwest NC	None for annual campaigns, land, publications or conferences	Average $1,000 - $25,000	Henry M. Carter, Jr. Executive Director 310 West Fourth Street, Suite 229 Winston-Salem NC 27101 (919) 725-2382

Additional Sources of Funding Information

The Scientist. The Scientist Inc. (312) 762-2193. This periodical has a Profession section that includes news about both grants and grant makers.

The Chronicle of Philanthropy. The Chronicle of Higher Education. (202) 466-1234. This publication includes news of interest to both grant givers and grant seekers, including lists of grants awarded by nonprofit associations and foundations.

SCI/GRANTS News. IMV, Ltd. (800) 27-Grant. This publication focuses on grants that fund the purchase or improvement of equipment or facilities.

Federal Register. Superintendent of Documents. U.S. Government Printing Office, Washington, D.C. 20402.

Commerce Business Daily. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Foundation Center. 888 Seventh Avenue, New York, NY 10106. To order publications or a catalog, use their toll-free number, 800-424-9836.

NIH Guide for Grants and Contracts. Available from NIH Guide, Printing & Reproduction Branch, National Institutes of Health, Room B4BN23, Building 31, Bethesda, MD 20892.

Principles of Success

by Tom Wolff, AHEC/Community Partners

A generic set of principles for successful coalition development can be quite a challenge to generate in light of the great variation in what is called a 'coalition'. Not only do the definitions of coalition vary (from two agencies joining together in a grant submission through a broad community group with representatives from every sector) but also definitions of coalition 'success vary (i.e. we have succeeded if we get the Chief of Police to join our coalition vs. we have succeeded if we get the Chief of Police fired).

❑ ASSUMPTIONS:

To clarify the principles of success in a brief paper it is necessary to first spell out some of the basic assumptions of the particular approach to coalition building articulated in this model:

1. Ecological approach - individuals are understood in the broadest context of their environment. Thus when examining social problems (i.e. drug abuse, teen pregnancy) always consider the major forces in American life today that impact on the problem including: racism, sexism, class elitism, injustices, and economic maldistribution of resources.

2. Social change - Coalitions are committed to addressing those components of society that require change as opposed to improving ways to adapt to societys ills.

3. Multisectoral-multicultural approaches - Coalitions need to include everyone in a community. The coalitions basic principles must celebrate diversity and must value the multicultural characteristics of their communities. Institutional racism needs to be identified and addressed. In communities of color, empowerment of their own community may precede multicultural efforts.

4. Capacity approach - Coalitions focus on a community's capacities and strengths as well as its deficits and problems. They focus on individuals as citizens rather than clients.

❑ PRINCIPLES:

MISSION AND GOALS

Coalition members will clearly define their shared mission/goals and see to it that the identified goals incorporate the self-interests of the various constituencies. Coalition building requires both a willingness to set aside personal agendas for a common good, and a realistic understanding that addressing the self interests of participants is crucial. Walking the tight rope between these agendas is critical to coalition success.

INCLUSIVE MEMBERSHIP

Membership in coalitions needs to be inclusive, allowing all members of a community who endorse the coalitions mission to join in the coalitions efforts. Inclusive membership will occur only through active recruiting of the two power extremes in the community - the most powerful (business, clergy, city hall, etc.) and the least powerful (neighborhood groups, youth, people of color, the poor, etc.). The geographic boundaries of the coalition will also be decided by those directly involved.

ORGANIZATIONAL COMPETENCE

The coalitions organizational functioning and structure must be clear and competent enough so that the coalition can perform basic tasks effectively. This includes:

a. Effective leadership - coalitions need to have clearly identified leadership structures but also need to share leadership as broadly as possible. Building new leadership is a crucial role for coalitions especially among community groups which have been disenfranchised.

b. A clear, democratic decision making process is needed which allows for broad input into decisions and for conflict and disagreement to occur and be resolved.

c. Most broad coalition efforts require experienced staff. The staff must have group and organizational process skills and community development philosophy and skills.

d. Coalitions need to proceed in a planful manner and thus must develop at least a rudimentary ongoing system of planning.

e. Active and effective communication among members of the coalition and between the coalition and both the community and outside systems (i.e. the State) is critical.

f. Mobilization and effective use of resources from within the coalition, and outside, is essential.

ACTION AND ADVOCACY

Successful coalitions take actions that are doable and thus prove their effectiveness to themselves and their communities through concrete results. This often means that coalitions load experiments for success to guarantee early victories that will illustrate to the members and the communities that change can occur. A short agenda of doable tasks also prevents a coalition from spreading itself too thin.

HOPE AND CELEBRATION

Coalition activities need to include fun and must affirm the strengths and joys of the community. Indeed one of the great gifts of effective coalitions to their members and to their communities is the gift of hope that emerges from an optimistic coalition approach that says that most problems <u>can</u> be effectively addressed. Leaders will help emphasize the hope and accomplishments of the coalition and help the coalition celebrate this process.

TIME AND PERSISTENCE

The agendas of broad coalitions that address the quality of life in communities can be overwhelming. The coalition needs to take a long-range view, understanding that the coalitions agenda will take time and persistence. Although some single issue coalitions are defined as short-term efforts, the coalitions described in this model will create the needed societal changes only in longer time frames. Tackling big issues in manageable pieces holds for both long term and short term efforts.

MONITORING AND ASSESSMENT

It is obvious that the process of developing a coalition to address quality of life issues in a community is very complex. The literature can provide us with some direction, but each coalition effort must be guided by its own internal review and evaluation process. Whether this review is done at an annual meeting discussion of the coalitions process and outcomes or through a more rigorous evaluation scheme, an effective coalition will have the capacity to learn from its successes and its disapointments, for it surely will have both.
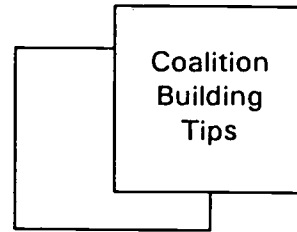
❑ CONCLUSION

The above principles are a 'work in progress'. We hope they can be used as helpful hypotheses to be tested in various communities. We welcome your feedback, suggestions, disagreements and additions.

The above thoughts were partially drawn from the work of Citizens Committee for New York City, Lew Finfer, Herb Shepard, and David Chavis.

AHEC/Community Partners
24 South Prospect Street
Amherst, MA 01002

One in a series of tips on building coalitions.

Coalition Start Up

by David Foster and Heather Danton, AHEC/Community Partners

The impetus behind each new coalition - that spark or particular combination of concerns and people - is unique. No two coalitions begin or develop in precisely the same way. There is not a specific linear order in which this process evolves since a coalition's processes, its structure and its activities develop interactively. Still, there are common themes, elements and stages that most coalitions concerned with community issues go through in getting started.

❑ Context

First, it is important to be aware of the environment within which the coalition will emerge and function. Some key variables include:
- definition of "the community"
- social infrastructure
- history of collaboration and "political climate"
- nature of existing helping systems
- resources (human, organizational, and material)

In the early stages of any new coalition, it is valuable to consciously consider each of these elements and assess its potential influence on the emerging group and its process.

❑ Who, What, Where, Why?

At the outset it is useful to examine questions related to "why are we coming together". Some coalitions form when a history of working together on a common concern leads to a desire for a more formal, ongoing organization. Recently more coalitions have emerged in response to some external impetus, often from a funding source. These groups face a special challenge of not being driven, divided or distracted by these outside forces.

As a group comes together to initiate a coalition, the issue of "boundaries" will come up in several forms. Questions, such as, what are we about?; what do we want to do?; what geographic area will the coalition focus on?; and, who should be involved? will emerge. Preliminary answers to these questions will be developed in the beginning, but they will also resurface and get refined as the group reassesses its purpose and direction over time. It is critical to have a clear understanding of what the coalition's "community" is. It is best to define the community in a way that is meaningful in the minds of people who live and work there, rather than to simply rely on political or bureaucratic boundaries.

In this early going, there is usually a key person(s) who provides the leadership and supports the communication necessary to establishing a new organization. It is helpful for this person and her/his affiliation to be seen as "neutral" and accessible.

❑ Agenda

Early on, a coalition needs to consider the nature and scope of the agenda it desires, understanding that this is likely to evolve over time. There are four broad areas that coalition agendas generally encompass: 1- sharing (information); 2- relationships (support); 3- action (collaboration); 4- change (reallocate resources/power).

❑ Focus and Content

Coalitions must define their focus and content in order to facilitate the process of defining a mission and goals. A few key focus issues are discussed below:

a) Target population: Some coalitions take a broad approach and include all residents of an agreed upon geographic area within its overall agenda. Others take a more specific focus related to a particular age, gender, racial/ethnic or economic group.

b) Agenda issues: Community coalitions often embrace a broad issue agenda which addresses the community's quality of life, taking action on a series of priority issues over time. Other coalitions may choose to focus on a more specific agenda issue such as substance abuse, AIDS, or teenage pregnancy in response to members' experiences/concerns, community-derived needs assessments, or funding opportunities.

❑ Membership

The challenge for any coalition is to define its agenda so that it is both meaningful and "safe" for as broad and diverse a membership as possible. In considering membership, several questions emerge: will the coalition have a formal membership?; what does it mean to be a member?; what involvement or commitment (time, resources) will be expected?; who ought to be included as members?; and, what kinds of outreach are needed?

Encouraging more inclusive membership is recommended. A larger, more diverse membership allows the coalition to discover the interconnections among a variety of populations and issues which can lead to unanticipated new ideas and opportunities for strengthening the coalition, its members and the community.

❑ Leadership, Structure, and Communication

As groups develop, grow and become more active, most begin to feel the need for a more formal structure, including designated leadership and some staffing. Another key issue that comes up, particularly when funding is discussed, is incorporation. It is also important to point out that while good communication is a key element to the entire start-up process, clear and regular channels of communication are essential to defining and maintaining coalition structure.

❑ Planning

The final step in the start-up process is the development of a formal planning process. Definition of a clear mission statement, goals and work plan are prerequisites to maintaining focus, energy and productivity. A formal plan also helps to make the coalition's boundaries and direction explicit, thus supporting coalition members and committees in developing their ideas and moving them to action.
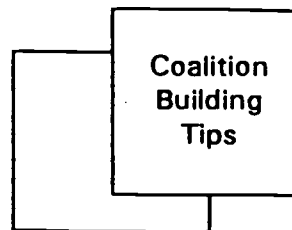
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One in a series of tips on building coalitions.

Coalition Membership

by Tom Wolff, AHEC/Community Partners

The definition of coalition membership varies widely. Often the mission or funding of the coalition predetermines who the membership will be. Generally in the AHEC/Community Partners coalitions the mission is defined as improving the quality of life in the community. Under this broad mission statement the logical definition of membership would include anyone who can endorse and work on that mission. Thus anyone in the community who is willing to work on improving the quality of life in that community is considered eligible to be a member. This may be one of the broader, more open membership definitions among the array of coalitions. Below we explore a number of issues that help clarify the limitations and opportunities that are established by various definitions of membership.

❏ Inclusion, Exclusion

The group development literature informs us that inclusion and exclusion are key variables in the start-up of any group. Coalition start-ups are no exception. Initial coalition discussions about who should be invited, and who should not, are often among the coalition's first decisions. We often hear 'don't invite him, he's a troublemaker'. 'We don't want people from that town, because they're different from us'. 'Let's make sure we get the Mayor and the Chief of Police, we need them'. If one makes the assumption that the goal of the coalition is to mobilize as many resources from as many sectors of the community as possible to work on community issues, then one needs to make initial membership decisions that would create a sense of equal access to the coalition. Developing and maintaining the open membership system requires a constant examination of coalition practices. Do new members get introduced when they arrive? Do they feel welcomed? How does one bring new members up-to-date on what's happening? If coalitions limit who can be members, who can be on steering committees, whose resources they are interested in tapping, then by definition they are excluding people from the community and the coalition will not be able to tap into their capacities and resources to solve the community's problems. Often coalitions decide to start off small, and try to increase their inclusiveness as time proceeds. The difficulty with this approach is that when others come on board they can feel that critical decisions were made without them. An inclusive approach requires addressing the issue at the start.

❏ Money and Membership Issues

Many coalitions ask people who are members to show their support by paying a fee to cover coalition expenses. How the issue of money and membership is constructed will have a large impact on the coalition. If the coalition sets the fee as a membership fee, then it says a member is one who pays the fee. An alternate approach is to say that anyone who supports the mission of the coalition and signs up as a member is a member, and those who are able to provide financial support become sponsors of the coalition. This separates the issue of membership from financial support. By setting a fee as a membership criteria, one potentially eliminates low-income citizens, even if one establishes a scholarship or sliding fee scale, since having to make requests for that can be a humiliating experience. Balancing the need to obtain financial support from members, with not excluding people based on fees is a key issue around membership in coalition activities.

❑ Activity Level

Although membership can be claimed by those who sign up as members or those who send financial support, the key component of coalition membership is activity. Without coalition members providing their time and their efforts, there is no coalition. Thus, a key factor in the success of any coalition is the amount of energy and time invested by its members in the community. No matter how many people have paid their dues, if you cannot get members to sign up for activities and task forces, the projects that the coalition takes on will fail. Marian Wright Edelman of the Children's Defense Fund, in talking about developing teen pregnancy prevention coalitions, says that we need to distinguish between the talkers and the actors. Often at the beginning of the coalition, we see more of the talkers and only later do we see the actors. Thus, another important factor in assessing membership in a coalition is to examine the activity level.

❑ Multi-Sectoral, Multi-Cultural Coalitions

How well the coalition membership represents the various sectors and sub-cultures of a community is another key variable in membership. For membership to be truly representative, efforts have to be made to reach those who don't easily come to coalition activities. The hardest to reach individuals tend to be those at the very top of the power structure: the heads of corporations, police chiefs, superintendents of schools - and those at the very bottom of the power scale: the disenfranchised, the citizens. Specific efforts involving individual, personalized outreach need to be focused on those groups not well represented, so the coalition can be both multi-sectoral and multi-cultural. Getting these hard to reach individuals into the room is only the first step, the coalition will need to create a welcoming environment if the newcomers are to stay with the coalition. Without this, the strength of the membership will be weakened.

❑ The Role of Citizens

Although coalitions proclaim themselves as empowering institutions, giving voice to the members of the community, they often fail at involving citizens in their efforts. Coalitions are often quite successful at engaging certain components of a community to interact in daytime meetings, in formal settings. But this modality has enormous barriers to involving grassroots citizens, barriers including: time, money, language, family responsibilities, transportation, etc. There are no simple answers as to how to best engage citizens in coalition activities. To change the meetings to evenings, provide interpreters and day care may be ways of enticing citizens to a meeting, but on is likely to lose many human service providers with after work events. One should not assume that coalition building efforts and citizens community development activities can always be, or need to be, merged into one organization. Rather, we must seek the areas of overlapping interest of these initiatives. There needs to be an active exploration of how neighborhood organizations, community development groups, citizen action groups and community coalitions can find common ground and ways of collaborating. This indeed may be the greatest future challenge for coalition membership.

The strength of a coalition is really the sum of the capacities of its members. Seeking a broad representation of active members and maintaining an open door are critical to coalition success.
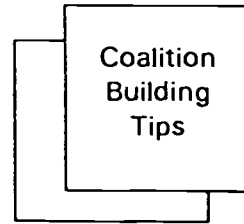
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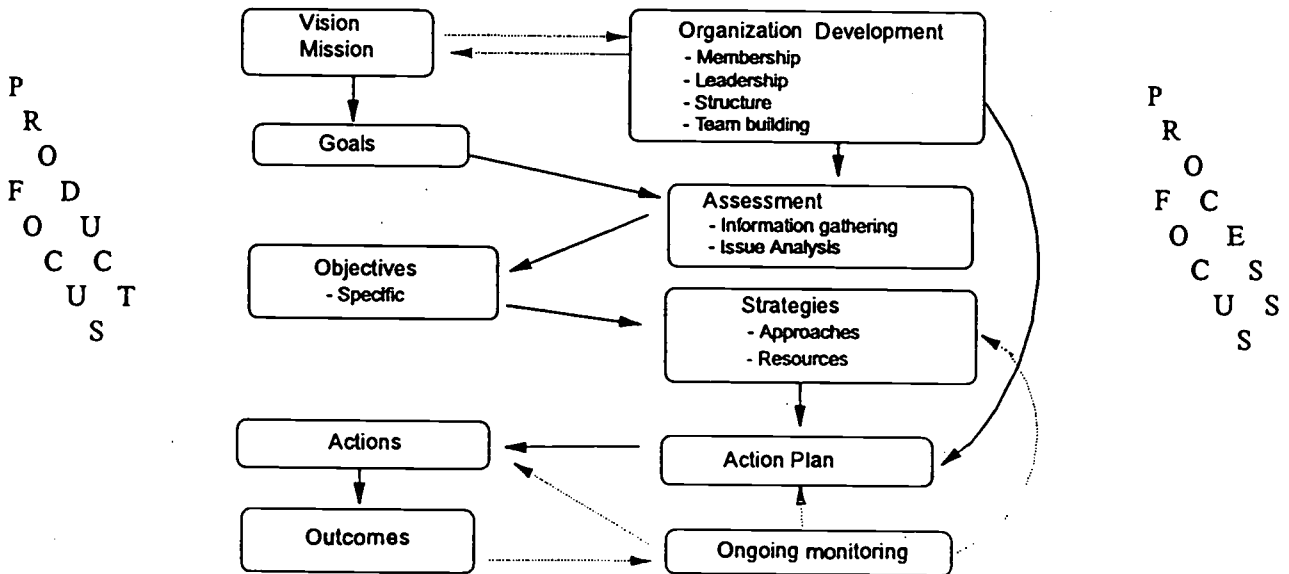# Coalition Planning

by David Foster, Community Partners

"If you're not sure where you're going, any road will get you there," said some wise person, but the journey will likely be a meandering and unsatisfying one. Coalitions, particularly new ones, often struggle with the consequences of this. Unless they are required by some external force (e.g., a funder) to have a clearly articulated plan, there is often little inclination to do real planning. This may be due in part to the absence of structure, particularly hierarchy, at the outset. If it's no one's "job" to instigate the planning, it often doesn't happen. Activity often results from reacting to a crisis or taking on some member's special concern, but there is no mechanism for taking a long view, setting priorities, or being proactive.

Planning by coalitions is designed to systematically define the desired products (destination) and develop a workable process (route) that results in the actions needed to create the desired products. As shown in the diagram below, there are several stages in defining the desired products, each becoming more specific, and several aspects of process which, when woven together, lead to concrete action and the desired outcomes, if all goes well.

The planning scheme described here represents a comprehensive approach that will be useful for most coalitions. In reality it is rarely followed in its entirety, often due to a feeling that it takes too much time or that the group already knows what needs to be done so 'let's just get on with it'. While a variety of short cuts may be taken without serious ill-effects, in the long run coalitions are most productive when they adhere to good planning.

For the readers to whom this is familiar, perhaps it may serve as a reminder of its applicability to coalitions.

☐ Vision/Mission

Early in a coalition's development it is important to establish a written mission statement which articulates a broad sense of its common purpose. This establishes the overall arena in which the coalition wants to work and how it hopes things will be different in the future. For some coalitions this is a straight-forward task, for others it is the product of considerable labor and negotiation. *EXAMPLE: The mission of the Coalition is to enhance the quality of life for all residents by ensuring that community resources are maximized and visible, through education, advocacy and action.*

☐ Organizational Development

The work of building the coalition into a viable organization goes on in parallel with product-focused work. It is interactive with vision/mission development since the concerns of those initially at the table frame the mission, which then defines who needs to be at the table and how they should be organized (e.g., formal vs. informal). As part of organizational

development, a sound structure is needed, with committees or work groups that will do the work and bring their findings/ recommendations back to the whole group for review. *Officers, Committees (Executive, Substance Abuse, Community Health Education, Community Relations, Membership)*

Ongoing attention to team building is essential and needs to be part of the planning process.

☐ Goals

Defining goals helps give focus to the broad direction by establishing the basic domains that need to be acted on and the general outcomes that will help achieve the mission. *To educate community residents about health issues affecting infant mortality.*

☐ Assessment

Once these broad goals are established, a variety of information is often need before they can be operationalized. The assessment process involves gathering information and analyzing it. It addresses questions such as: what are the real issues involved in achieving these goals? what needs to be done to achieve them? what forces are already at work? who's affected, interested or already involved? what are realistic outcomes - amounts, time frame?

☐ Objectives

With the information from the assessment process, the group can develop specific objectives. These serve to define the desired outcomes in more precise terms, with quantified targets and time frames whenever possible. *Train two teams (10-12 people each) of community health outreach workers in the next eighteen months.*

☐ Strategies

These specific objectives lead directly to a discussion of strategies - how do we get there from here. What needs to be done? Who needs to be involved (who will be most affected)? What material resources are required? How can they be obtained? What barriers can be anticipated and how might they be overcome? What is the best sequence of activities? These discussions are about building a strong, well-thought-out foundation for action. *Have coalition staff work with tenants' council to recruit neighborhood residents; get coalition members to volunteer as trainers.*

☐ Action Plan/Actions

With these strategy questions answered, it is a relatively simple task to devise a written plan for action. This lays out specific action steps, in sequence and/or in parallel, to implement the strategy. The plan should identify a specific individual or work group who is responsible for each action and set time frames for its completion. *Within two weeks, "X" will recruit "Y" and Z" from the coalition to teach 2 sessions of the training.*

The implementation of this plan by coalition members is in some sense the culmination of the planning process, leading to the outcomes defined in the goals and specific objectives.
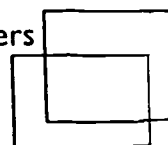
☐ Ongoing Monitoring/Evaluation

But how do we know that all is happening the way it's intended? Ongoing monitoring is a critical process of keeping track of what is supposed to be happening and how things are going. It asks if the people assigned tasks in the action plan are getting them done. It then considers how we know what the actual outcomes of the completed action are, and whether they are what the coalition had intended (in terms of type and amount). Finally, it asks what adjustments in earlier steps (strategies --> actions) may be needed to improve the quality or quantity of outcomes. *At each Executive Committee meeting the prior months' minutes are reviewed to assure there has been follow-through on tasks assigned.*

An evaluation steps back further to see if the mission is still valid, if the goals need to be updated, if the structure is working effectively, if the group's work is valued by those within and/or outside the coalition, if member morale and commitment are high, etc. *There will be an annual member satisfaction survey to determine how the coalition is, and is not, meeting the members' expectations.*

This process is doable, but it requires a collective discipline within the coalition, along with a willingness to take the time needed to help assure a better outcome and thus a more sustainable coalition.
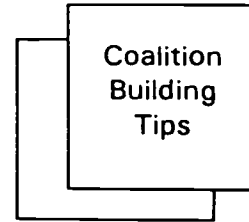
One in a series of tips on building coalitions.

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Coalition Leadership

by Tom Wolff, Community Partners

☐ Coalition Leadership

Coalition leadership requires attention to basic organizational functions - communication, clarity of roles, decision-making, etc. - just as in other organizations. However, in some ways, coalitions are unusual forms of organization and raise special leadership issues.

☐ Types of Leadership Structures

How leadership in coalitions is defined and how it functions in coalitions vary enormously. Some coalitions have <u>paid staff</u> which may be part-time or full-time; and either from the local community or not. In large, well-funded coalitions, we often find organizations with a full-time director which look a great deal like a traditional human service agency. In other coalitions, leadership is a <u>totally voluntary</u> capacity and emerges solely from the membership. Finally, in a third form, we see some <u>combination of paid and volunteer leadership</u>.

☐ Coalition Leadership Models Vary with Coalition Goals

Depending upon the goals of the coalition, a variety of these styles may prove to be effective. One coalition might be run by a specific charismatic leader, while another coalition's leadership might be shared among several different individuals. In this insert, we describe leadership issues as applicable to coalitions which have as their goals bringing together various components of the community to become more effective problem solvers and to maximize the use of resources in the community. Those goals require a commitment to community development, and thus a shared leadership model tends to be the one that seems most effective in achieving these goals. For coalitions that have a commitment to community development, not only is the involvement of existing leaders critical, but developing new leadership is also adopted as a goal.

☐ Skills and Style

Critical skills and styles for coalition leaders include:

- **An inclusive, welcoming stance:** Coalition leaders should set the tone for welcoming new members and for bringing them into the coalition. Orienting new members and urging them into active roles are part of the welcoming.

- **Excellent communicators:** Both in verbal and written materials, coalition leaders need to take complex materials and make them understandable to all audiences.

- **Group facilitation skills:** Coalition leaders need to be able to guide both large and small meetings, with numerous participants and various agendas. Meetings would allow everyone to have their say, and yet be able to follow agendas, move through problem-solving processes and ultimately make decisions.

- **Conflict resolution:** It is helpful for coalition leaders to appreciate the benefits of conflict, since conflict is a regular part of what happens in coalitions. Seeing conflict as an opportunity to be grappled with, rather than a horror to be avoided, is crucial to coalition leadership. Identifying the various self-interests, seeing the common ground, and helping to seek compromises are part of this activity.

- **Sharing the spotlight:** Coalition leaders must leave their egos at the door and be able to share the glory and the spotlight with other coalition members and other entities in the community. This can be a complicated tightrope - being too modest can lead to the coalition remaining invisible, being too forward may bring resentment.

- **Trust:** Coalition leaders must be able to engender trust in those with whom they work. They must be reliable, prompt, honest and true to their word.

Finally, coalition leaders must bring energy and hope to coalitions in both their styles and their skills. One can easily see how hard it would be to find one individual with all the above traits - thus the advantages of a shared leadership model which calls upon many individual's skills become more obvious. Also clear are the risks of relying on a single leader to be the initiator of all coalition activity.

☐ Specific Issues and Challenges of Coalition Leadership

Delegation
The role of coalitions as catalysts instead of doers is paralleled in the role of the coalition leaders. The leaders must also be catalysts for action instead of doers of the action. An excellent program manager and program developer who knows how to get things done can actually be less successful as a coalition leader, since s/he may not foster delegation and develop new leadership. Coalition leaders must support the active engagement of all members, and seek support for themselves from others in the coalition.

Juggling Responsibilities, Roles and Time
Coalitions, when they start to become effective, open more and more doors with each success. Balancing these various opportunities and obligations is critical. Numerous coalition leaders suffer from making too many commitments and spreading themselves, and the coalition, too thin.

Jealousy and Criticism
Coalition leaders often are the target of both criticism and jealousy. Being central and visible figures, these negative reactions can occur quite separate from any inappropriate action being taken by the leader. Understanding that this is a natural part of group process is a necessary stance for the leader. Constructively dealing with both criticism and jealousy by listening and responding non-defensively is necessary for the feelings to diminish.

Action Orientation
Many coalitions get bogged down in lengthy planning processes or in cautiously avoiding controversial issues. Coalition leaders must be able to move the coalition towards action and accomplishments, so that coalition members can keep a balance between the time that they put in and the benefits they reap from the coalition's accomplishments. This drive for products must be carefully linked with a thoughtful coalition process.

Paid Staff
Having paid coalition staff (versus only volunteer leadership) raises important issues:
1) When coalitions have paid staff, a key issue is the differentiation of tasks to be performed by staff vs. coalition members. As unpleasant tasks arise, do all eyes focus on the paid staff and does the staff person take on the task or try to delegate it? And if s/he tries to delegate the task, do coalition members help or do they leave it for the staff person? The ways these scenarios play out can decide the tone of the coalition.
2) Supervision and support for paid staff is a second key issue. The high-stress job of being a coalition staff person requires skilled supervision and support, which is rarely available. The supervision needs to come from one or more individuals with practical knowledge of coalitions, group process, conflict resolution, etc.
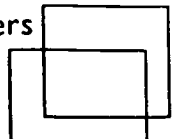
Developing Leaders
Coalitions vary in their commitment to developing new leadership with the coalitions and in communities. When leadership development is a stated goal, it creates new leadership issues. Specifically, one needs to decide if new leaders are going to be sought from professional ranks, or from citizens. And then existing coalition leaders play a key role in modeling, mentoring, training and encouraging new leaders.

"Team leadership enhances the possibility that different styles of leadership can be brought to bear simultaneously. If the leader is a visionary with little talent for practical steps, a team member who is a naturally gifted agenda-setter can provide priceless support. No one knows enough to perform all the functions in our most demanding leadership posts today." - John Gardner, The Nature of Leadership, Independent Sector, 1986.
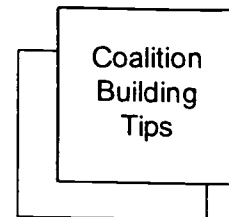
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One in a series of tips on building coalitions.

Evaluating Coalition Efforts

by Vincent Francisco and Tom Wolff

Coalition evaluation is often a mystery for staff and membership. As a result, coalitions often hire outside evaluators and leave the evaluation to them, accepting whatever recommendations are made because they are the "experts." This isn't necessary, nor is it recommended. The coalition is the primary consumer of the evaluation, so care should be taken to do evaluation correctly from the start and avoid problems later on.

In this Tip Sheet, we will explore some issues to consider before undertaking an evaluation; criteria for a successful evaluation; questions you may wish to answer through evaluation; and how you can answer those questions. While this won't replace the need for an evaluation specialist, it should help you when hiring an evaluator and using evaluation data. It will also help you understand evaluation language, which may be more than half the battle.

❑Why Hire An Evaluator?

There are several reasons to hire an evaluator. One of the most compelling is that you may be told to do so by your funder. Some funders even specify which one. You may want an evaluator to improve the functioning of your coalition, or to acquire information for new or continued funding. All these reason (and more) are certainly valid. The important thing is to be aware of what your reasons are, and of how much control you have over the final product. If an evaluator is specified by your funder, you may have little control over the evaluation or the relationship (beyond refusing the money, that is). However, even in this situation, the evaluators should be responsive to your needs and the local culture. And in all cases, you should be clear on what you want the evaluation to *do*.

❑What Are the Criteria for a Successful Evaluation?

•Strategic Planning

In our experience, several key factors contribute to a successful evaluation relationship. The first is strategic planning within the coalition. This should include development of a mission or goals statement, and a list of objectives (with a timeline). It can also include the strategies to be employed and detailed action plans, stating who will do what by when. Your strategic plan should flow from some type of needs assessment that identifies relevant issues, barriers, resources, and culturally appropriate ways of dealing with problems. Aside from encouraging clear thinking, a strategic plan helps you and the evaluator know what will be evaluated. When you know this, that's a big step forward.

•Sensitivity to Local Culture

Make sure that the evaluators are sensitive to local culture (ethnic and political) and can speak your language (figuratively and literally, using translation when called for). The evaluators should also be presenting the information in clear, direct, user-friendly formats. You want them taking to and with the coalition membership and funders — not down, not up, and not sideways.

•Contributions to Coalition Improvement

Your evaluation should improve your coalition. Make sure that the evaluation includes ongoing feedback in a style you can use to strengthen coalition planning and activities. In every case, you and the evaluators should apply a *utility criterion* to the evaluation methods. That is, will this evaluation give us information that will be *used* by the coalition and its members, the funder, the community, etc? The evaluation hasn't much value if it can't be translated into action. If it won't be used, don't do it.

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□What Questions Should the Evaluation Help Answer?

•Process Evaluation: What Activities Took Place?

This kind of evaluation focuses on the *day-to-day activities* of your coalition. Methodologies here may include activity logs, surveys, and interviews. Key variables might involve in-house developments (committees adopted, staff hired), outside meetings, communications received, funding generated, community participation, and media coverage. Surveys can be done rating the importance and feasibility of goals, and rating the satisfaction of the membership with coalition implementation. Process evaluation might also include an analysis of critical events in the development of the coalition, using semi-structured interviews.

•Outcome Evaluation: What Was Accomplished?

This kind of the evaluation focuses on the coalition's *accomplishments*. It can include the number and type of changes in policies or practices in the community, as well as the development of new services. It can also be useful to do surveys of self-reported behavior changes (such as alcohol and drug use), as well as surveys rating the significance of outcomes achieved. The number of objectives met over time is also a useful outcome evaluation tool. The outcome evaluation can be further supplemented with interviews on critical accomplishment events.

•Impact Evaluation: What Were the Long-Range Effects

This kind of evaluation focuses on the *ultimate impacts* the coalition is having on the community, over and above specific outcomes. The focus here is often on statistical indicators. For example, a substance abuse prevention coalition might focus on collecting data on alcohol-related nighttime single vehicle accidents, or the number of drug-affected babies born in the community. A teen pregnancy prevention coalition might focus on the pregnancy rate for its locale. These data can be graphed with the data on coalition accomplishments to show a relationship between changes in the community and a decrease in problems in living. When interpreting such data, keep in mind that problems in living, such as drug use and teen pregnancy, are incredibly complicated — even the efforts of ten coalitions might not directly reduce the problem immediately. But you will make a difference if you reach the entire community affected by the problem, in ways appropriate to the problem and the community.
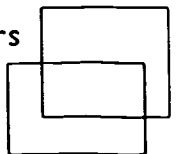
The above is only a partial list of questions compiled from our experience. You may have additional ones. The important thing is that from the start you and your evaluators should identify what questions you need to answer and how you will answer them. This can be done most easily from your strategic plan, with its objectives and actions.

□In Summary

Evaluation is important. Very important. It is best done in the context of strategic planning so that you know what it is you are evaluating. Consider what questions you want answered. Match your data collection methods to those questions. Make sure that feedback occurs, and that your evaluators provide it in a fashion that meets your needs. Then use the evaluation feedback to improve your coalition.

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One in a series of tips on building coalitions.

Stages of Development in Community Coalitions

by Tom Wolff, AHEC/Community Partners

It is helpful in trying to understand the stages of coalition development to draw from a variety of perspectives and literatures. There is a great deal written and discussed about coalition start up, but much less is written about coalition maintenance. There is a dearth of coalition case histories that reflect how they grow over time and are sustained. In this brief paper, we look at the individual, the group, and the whole coalition levels to gain some understanding about developmental stages.

❑ Individual Level of Development

The experience of individuals in coalitions and their sense of connection to community are strikingly similar to the theories reflected in the writings of Jean Baker Miller. Her writings on the psychology of women and the process of the development of connections by women provide a perspective that can be applied to our sense of what individuals go through in coalitions.

Miller suggests that there are five steps regarding connection. The first is that as individuals make an initial connection, they find themselves having an increased sense of well being, and an increased amount of zest. This energy is easily seen at initial coalition meetings when people get quite excited about being part of a larger whole. In the second stage, the initial zest leads to increased motivation to be active in the relationship, and they therefore feel empowered to go beyond the relationship. This is also true in coalitions where after the initial excitement, individuals often start to reach out to other agencies or other individuals within their own agency, to start to make connections. The third stage suggested by Miller involves increased knowledge of themselves and others, and increased clarity of feelings and thoughts. We also see this in coalitions, where as a result of connections with others in the community, individuals feel clearer about what's happening with each other and feel clearer about their piece of the whole. Fourth is an increased sense of worth that results from the connection, and this has been reported by our researcher Judie Post from her interviews with long-term coalition members. They report that an increase in their own sense of self worth is a clear outcome of their coalition experience. Finally, there is a desire for more connections. And that is also clear in coalition behavior. What happens in coalitions is the cumulative effect of numerous individuals interacting. Miller's description of the process of connections has a strikingly similar tone to that which we experience in coalitions.

❑ Group Level of Development

Studies of group process also generate predictable development sequences. Tuckman, typical of many, suggests four such stages. Groups begin by concerning themselves with orientation to the group, including issues of inclusion and exclusion, understanding of the boundaries of the group, testing the limits, and clarifying leadership. This is often discussed as **forming**. These initial issues are clearly the same questions asked at the start of coalitions. The second point in the sequence is generally characterized by conflict and polarization around various issues, and increasing emotional tone. Coalitions that allow for emotional expression and willingly face conflict will reveal these issues in public, otherwise we hear them through the grapevine. This second stage is often described as **storming**. As the group works on resolving the conflicts, there is an increased sense of cohesiveness, and new roles for group members begin to emerge and are adopted. This stage of the process is described as **norming**. We often see this in coalitions as the initial productions and activities of task forces and joint advocacy. In the final stage of group process, called **performing**, the group becomes much more functional, the group's energy is channelled into appropriate tasks, structural issues have been resolved, and the structure can now be supportive of getting the tasks done. Successful coalitions have been able to create structures that allow them to function, and also to get past the interpersonal conflicts, so that they can perform - as described in the group process literature.

❑ Coalition Level Development

In her book <u>Collaboration,</u> Barbara Grey writes expansively about the stages of development of whole coalitions in collaborative efforts. Grey suggests three phases. Phase one is the **problem setting phase**, in which stakeholders are identified and their issues of mutual concern are acknowledged. The specific tasks that need accomplishment within the problem

setting phase include:

- stakeholders must identify that their actions are dependent upon the actions of each other;
- stakeholders that are identified must represent a wide variety of the key components of the community and must be perceived as being legitimate stakeholders;
- a legitimate and skilled convener with process capacity must be identified and given authority to have the role of convener, and;
- all the stakeholders must agree that their shared vision and direction is of great enough value to outweigh the costs of such an effort.

For coalitions, this translates to the kinds of issues and statements one hears early on, such as, "why should we do this", "what do we have in common", "is it worth it", "we've tried this before, it doesn't work", "what can we really achieve", and often ending with, "I'll try it, but no promises".

Grey calls her second phase the direction setting phase, in which stakeholders identify their common purpose, and the values which underlie these pursuits. It is here that mutually agreed upon directions start to emerge, and the dispersion of power begins to occur among the stakeholders. In coalitions, we see this as a period of time when the mission, goals and objectives are articulated, the leadership structure becomes defined, the specific leaders identified, and the coalitions start to take their first mutual actions.

The third stage Grey labels as the structuring phase. Here, the coalition begins to function in a systematic matter, and develops clear regulative functions. They begin to take their first actions which reinforce their beliefs that joint action can be beneficial; they begin to get some external recognition and mandate; and they begin to see the fruits of their labor. In coalition work, this becomes a critical phase and indeed can not be put off for too long. Stakeholders join coalitions tentatively, waiting to see whether indeed this new organization will have results, and unless early actions occur, they tend to be easily discouraged.
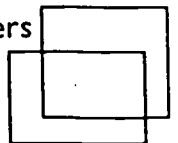
Beyond Grey's three stages come the major questions of coalition maintenance. If we are collaborating on a specific effort, the campaign wins or loses and the coalition dissolves, maybe to be picked up again some time in the future. In contrast, other coalitions including AHEC/Community Partners have lasted as long as ten years; then issues of maintenance become critical. Long term coalitions must reassess community needs, redefine priorities, engage new members and re-engage old ones. They need to develop coalition rituals and events that reinforce the values and the connections made through coalition work. Coalitions need to be very flexible, and not only respond in a planned, thoughtful manner, but also be available to deal with emerging crises as they occur. Throughout the history of a coalition, the cost-benefit ratio for participants must be attended to. We cannot become so busy with programs that we forget to ask all coalition members whether they are getting what they want. Most of all, maintaining this kind of process requires skilled staff, who in turn need to have solid support and guidance from knowledgeable supervisors. All of the above are the beginnings of ideas about how coalitions develop over time. Ours is still a very rudimentary understanding to which we all can add through case studies and longitudinal evaluations.

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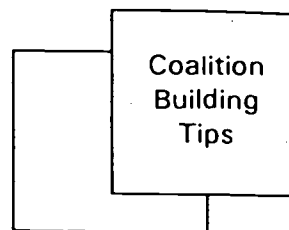3. Tuckman, B. (1965) "Developmental sequence in small groups" Psychological Bulletin, Vol 63, #6, p384-399.

One in a series of tips on building coalitions.

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Community Assessment

by David Foster, AHEC/Community Partners

Comprehensive and accurate community assessments are critical components of coalition development. To be most helpful, these assessments need to be guided by the following four criteria: they are designed to be resident-centered; they have a focus on community assets; they embrace a broad, inclusive vision, and they are designed to ensure follow-up.

Currently, most assessments of communities by health and human service organizations are needs assessments done by agencies either to justify the continuation of the services they currently provide or to establish the need for a specific service which they are interested in initiating. Additional uses, done in the aggregate by United Ways and other funding organizations, are designed either to establish the justification for fundraising or to guide the dispersement of resources based on a ranking of problems. There are several limitations to these traditional approaches.

First, the process of determining what problems will be included in the assessment and of defining how issues will be prioritized is usually controlled by, and limited to, professionals and/or civic leaders, omitting important citizen perspectives. Second, the focus is exclusively on the problems, needs, and deficits of individuals, families or communities, to the exclusion of strengths and assets. Third, this approach zeros in on today's urgent problems and does not help anticipate emerging concerns or opportunities. Finally, because there is usually little resident involvement in the assessment, nothing invests them in the results of the process or creates the openings to mobilize them toward addressing the needs and opportunities identified by the assessment.

In contrast, there are newer processes that operate from a different set of principles. Several alternative methods which reflect this perspective in varying ways are the focus of this insert. They have been used in many community settings both to gain information and to mobilize citizens for action. The results can help a young coalition set its course and recruit new members, while an established one can use the process to refocus its work and re-energize. These approaches lend themselves to use by coalitions that already have active community participation or that want to stimulate meaningful involvement.

The **Community Concerns Report** method was developed by Stephen Fawcett et al. to fill the need for a way to establish a community agenda for action that was citizen centered. Their method begins with a list of 300 possible concerns or issues, covering 18 categories of basic community functions, designed to be as inclusive as possible. "Unlike traditional survey research approaches, it involves consumers in selecting the issues to be studied and in interpreting the results." This is done through a volunteer work group, chosen to be as representative of the community as possible, who select the 30 or so items from the 300 that will constitute the survey.

The survey itself is designed to ask respondents two things: how important is that issue to them, and how satisfied are they with its current status. This provides both the level of interest in each item and the distinction between areas of strength (with high satisfaction) and problems (with low satisfaction).

Accompanied by a cover letter, the survey is distributed to all "consumers" of the organization or residents of the community, using a variety of methods depending on the number of people and the resources available. Incentives are sometimes offered to increase participation and to obtain the most accurate report of community opinions. The results are then tallied, showing the items with the highest importance ratings together with the highest and lowest satisfaction levels. These results are then shared at a well-advertized public meeting. The discussion is focused on each issue, with suggestions from citizens for preserving the major strong points and strategies for addressing the most serious concerns. From the survey and this public discussion, a report of the findings is prepared. The report is distributed widely, for use in community and organizational planning.

Another approach to community assessment, the **Social Reconnaissance**, has been developed by Michael Felix, David Chavis and others. This method is even more interactive than the Concerns Report, being referred to as a "barnstorming series of meetings". Chavis describes it as "inexpensive and easy, a manageable method for mobilizing a community toward solving its problems. The reassessment procedures themselves help to build new skills."

This method is built on a series of community assessment meetings organized by a community task force. The

meetings are designed for the participants to: share information about needs and resources within the community; develop ownership of issues and solutions; identify opportunities and barriers; and mobilize the community to action. Each meeting is facilitated by a person from the organization or community, with training and support from those organizing the process. The facilitator guides the group (ideally about 10 people) through a discussion of the areas listed above, using a structured process explained in the training, while a recorder captures the ideas shared by participants. The results from each meeting are compiled by the organizers and used to create a composite community assessment which is then shared back with the participants. From this process, action planning evolves around the priority issues.

Though both of the above processes look for strengths and resources, the work of John McKnight and his colleagues takes this interest to another level. They focus an entire process on the asset dimension alone. In their booklet, Mapping Community Capacity, they outline both the rationale for this approach and a method of identifying and organizing community assets. "The process of identifying capacities and assets [broadly defined], both individual and organizational, is the first step on the path toward community regeneration." In this mapping of assets, the assessment considers two important factors: where are they located; and by whom and from where are they controlled. They then create a picture showing the results. This provides a clear understanding about the accessibility of these assets to the residents, based on both geography and power.

One dimension of this assessment focuses on organizations - both agencies/institutions and community associations (such as service clubs, and church, artistic and sports groups), a resource of particular interest to McKnight. A second dimension is individual capacities which can be nurtured and utilized in building the community. The booklet includes a model "Capacity Inventory" used to collect information about personal skills, interests, etc. Finally, they map the physical resources of the community. With all this information compiled, groups interested in many forms of community building can use it to mobilize the community's assets for the benefit of the residents.

Each of these approaches offers something of value to coalitions interested in doing a new brand of participatory community assessment. Other more informal community assessment techniques offer some simpler mechanisms that can also meet the above criteria. Some that have been effectively used by coalitions include: door-to-door neighborhood visits, neighborhood listening posts, and focus groups. Each method has distinct features and requires somewhat different resources, but they are not mutually exclusive. If employed thoughtfully, these tools will yield more meaningful information, a more involved citizenry, and greater community efforts in capacity building and problem solving.

For more information on Community Concerns Reports:
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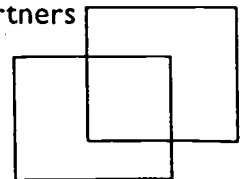
On Social Reconnaissance:
❏ Williams, "Rx: Social Reconnaissance," Foundation News, Vol. 31, No. 4, (1990)
❏ Chavis, et al., "Guidelines for Community Assessment Meetings," Unpublished document, Center for Social and Community Development, (1993) To obtain, contact David Chavis at the Center for Social and Community Development, Bldg. 4086, Room 139, Livingston Campus, Rutgers University, Piscataway, NJ 08855.
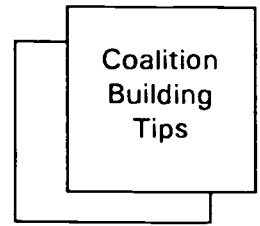
On Community Assets:
❏ Mapping Community Capacities can be ordered from the Center for Urban Affairs and Policy Research, Northwestern University, 2040 Sheridan Road, Evanston, IL 60208-4100; (708) 419-3395.

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One in a series of tips on building coalitions.

Engaging Residents In Coalition Building

by David Foster, Community Partners

Many coalitions begin with institutional leaders and service providers at the table. Either at the outset, or more often as the coalition evolves, the group frequently decides that community residents need to be more directly involved in the development of community agendas and programs.

There are a myriad of reasons why the participation of diverse community members is important. Among these are:
- insights of more people in defining the issues and priorities
- community ownership and investment in issues and solutions
- broader networks of people to inform and involve
- more energy with which to tackle projects

The benefits are clear, but deciding on the best approach to achieving this result is more elusive. Some coalitions seek to involve residents fully in the life and work of the coalition. Others focus on getting community members to participate on specific committees that work on community issues of interest to them, perhaps having included them in an assessment process for selecting the issues.

A third approach, which we find increasingly compelling, sees provider coalitions as facilitators, both for the development of neighborhood/community coalitions (if they do not already exist) and for providing technical support to resident-driven groups. The provider coalitions can then build ongoing partnerships with these neighborhood coalitions to better apply the resources of each to community capacity building and problem solving. We are coming to believe that in most communities this approach will be more effective in yielding successful provider-resident collaborations. Through these partnerships, community residents can discover and exercise their power in naming the issues, defining the solutions and being integrally involved in implementing these solutions.

This Tip Sheet identifies a number of issue areas to consider in designing typical coalition activities that will enhance the possibility for real community engagement - with related barriers to success, and some potential strategies. These concerns and ideas cover an array of challenges, although not all will apply to a given coalition (particularly those that are neighborhood based). It is useful, however, to review them all (and others you may add) when planning to reach out to expand community participation.

The more socio-economically diverse the audience, the more of these will likely apply. The ideas may be applied to provider coalitions, to their committees, and to neighborhood/community-based groups.

❑ ACCESS
Lack of transportation and mobility impediments are two common physical barriers to resident participation. Language can be an obstacle for those whose native language is other than English. When only certain people receive invitations to join, others may be denied access - whether by design or oversight.

◆Strategies: Meet in central location ◆ Offer rides ◆ Meet in "barrier-free" buildings ◆ Provide translators, bi-/multi-lingual publications ◆ Have open membership with broad outreach ◆

❑ AGENDA
Meetings that are focused on institutional or special-interest concerns - or that are formal, lengthy or disorganized - make it difficult to attract and retain community members.

◆Strategies: Have clear agenda based on broad member input ◆ Maintain action focus, based on group-set priorities ◆ Keep meetings to reasonable length ◆

❑ SCHEDULING

Finding a time when institutional, professional and community members can and will commit to meeting regularly is among the most difficult challenges. Monday through Friday, 9 to 5, works well for some and excludes others. Evenings are hard for most people with families - and for those who work, but do not live, in the community. Potential strategies for this issue are elusive; successful ones, rare. Most coalitions, at some point, face the choice of whether to lean toward the professional (daytime) and do the best it can to attract community members, or to lean toward residents (evening) and try to keep professionals involved. Another option is to establish parallel groups (provider and neighborhood) with open memberships, that maintain close communication and collaboration, as in the third option described at the beginning of this sheet.

❑COST

Out of pocket costs for participation, such as child care or transportation, can be a barrier to involving residents with low incomes. Lost wages due to missing work to participate in coalition activities is another.

✦Strategies: Offer child care or reimburse for care if needed ✦ Short meetings before or after work ✦ Offer rides or reimbursement ✦

❑"ISMs"

Professionalism in various forms can intimidate potential community members. Structural discrimination (racism, etc.) and tokenism are barriers to a diverse membership.

✦Strategies: Avoid jargon and "alphabet soup", value all types of input, use more informal meeting style ✦ Welcome diversity ✦ Outreach plan, don't ask 1-2 people to "represent" a sector ✦

❑INFORMATION

Unequal access to basic information about the group and its activities will impede the participation of neglected members. Inadequate background information about the group and its work can make it hard for new attenders to become full participants. Lack of knowledge about how the larger system works may inhibit the effective involvement of traditionally marginalized residents.

✦Strategies: Newsletter, other media ✦ Orientation, "buddy system" ✦ Training ✦

❑SKILLS/EXPERIENCE

Many potential members lack experience, and related skills, in being part of an ongoing problem-solving group. They often have little or no experience interacting with community leaders and decision makers, and lack training in how to deal with them effectively. Many have no role models to emulate in taking on these new experiences.

✦Strategies: Seek out/nurture existing or natural leaders ✦ Leadership training, mentoring ✦ Promote visibility of positive role models, job shadowing ✦
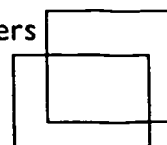
❑ Implications for Coalitions

A number of these strategies involve changes in how many coalitions conduct "business as usual." This requires that groups carefully assess the unseen impacts of their normal practices on the participation of community residents and make needed changes.
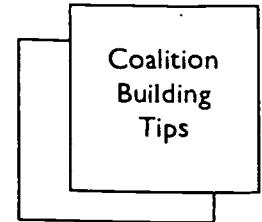
Other strategies call for outreach efforts, which to be effective must be well-planned, targeted and ongoing. For most coalitions, it is unrealistic to undertake this significant outreach without the support of paid staff, at least part-time. For the resident members to be in a strong position to plan effectively and to negotiate from a position of strength with public officials and professionals, as many as possible should be representatives of specific community constituencies. Thus one outreach strategy, within any approach, is to recruit initial resident participant through direct, personal requests for representation extended to diverse neighborhood and community organizations (both formal and informal).

One in a series of tips on building coalitions.

AHEC/Community Partners
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Money and Coalitions: Delights and Dilemmas

by Tom Wolff, AHEC/Community Partners

Most discussions of funding and coalitions deal solely with the issue of how to find funding to sustain coalition groups. In this Tip Sheet, we would like to start with an earlier premise, and ask the question, "Is funding really needed for coalition development?" It is interesting to compare coalitions that were started by grassroots groups with no money, versus coalitions that were gathered specifically around a funding source. In those coalitions that developed around a grassroots community issue, whether it is substance abuse, violence, or teen pregnancy, we see genuine community interest at the outset. Often, they have little or no money. When we contrast that with those coalitions that were started by the potential lure of dollars, we do not necessarily see a great level of community involvement. There is no question that some community coalitions have been highly successful with virtually no funding. We have also seen very well funded coalitions (one might suggest over-funded) fail. The keys to success remain the core principles of coalition success, such as: clear mission, organizational competence, time and persistence, etc. (For more on this, see our Tip Sheet "Principles of Success"). This raises fundamental questions about whether funding is always required for coalitions - and, if so, how much and what that funding is used for, and what are the kinds of problems, dilemmas, strengths and resources that are created by funding.

In our experience, we have seen the full spectrum - coalitions that had virtually no money, a moderate amount of resources to sustain the coalition efforts, or those with large amounts of resources to both sustain coalition efforts and develop community programming - be both successful and unsucessful. Funding in and of itself does not guarantee success or failure, but the degree of funding and the way in which decisions about the funding are made, create very different sorts of organizations.

❑ How Much Funding
Coalitions often need a certain amount of funding just to sustain their basic efforts of coordination, collaboration and information exchange. The "basics" include money for mailings, agendas, rental of meeting space, and enough money for an annual meeting. The next increase of funding for coalitions often pays for part-time or full-time secretarial support to do the clerical work that goes along with coalitions: mailings, minutes, newsletters, etc. Many coalitions also see the need for more skilled staff to assist with coalition planning, direction, leadership, facilitation, or mediation. After funding for the basics, and potential funding for staff, the next direction for coalition funds is specific programming. The programs developed: substance abuse prevention, teen pregnancy prevention, tobacco cessation, etc. are often determined by the availability of a particular funding source. Our experience suggests that when funding is obtained for coalitions it is best first spent on basics, then staffing, and finally programming.

❑ Funding For What
An important distinction should be made between coalition funding that goes to sustaining the process, the development, and the maintenance of the collaborative coalition process itself and coalition funding that goes into the development of programming. Once a coalition gets into the business of delivering programming itself, or subcontracting out dollars for programming to other agencies, it runs the risk of moving from a collaborative organization whose sole function is to promote coordination and collaboration to becoming another community agency. This can create a conflict where the coalition is in competition with its own members. Also risky is subcontracting program dollars to other agencies by coalitions. When a coalition does this, it needs to engage in a process of awarding and then monitoring the contracts. Subsequently, the coalition as a coordinating body also becomes a monitor of its own members, which creates an inordinately complex set of roles. In our experience, one set of functions often interferes with the other, meaning it is hard to be a collaborative partner with an agency if you are also monitoring a subcontract and potentially telling them that they are not doing a good job!

❏ Issues Created By Coalition Funding

• Money As Motivator

When coalitions are gathered together around the lure of external funding sources, one can never be sure that the partners at the table are not there just for the dollars. This leads to great ambiguity in the start-up of these coalitions. The best one can hope for is an open discussion of what brings people to the coalition table.

• Lead Agency

When a coalition gets involved with significant funds it sometimes finds a lead agency to handle these dollars rather than just a fiscal conduit or financial manager. The lead agency may then take on roles, responsibilities and power that place it on an unequal basis with other coalition members. Since one of the core premises of coalitions is that all members come to the table with equal power in the coalition, this can create difficulties.

• Decision Making

If a coalition does have resources beyond the core functions of process and staff, questions arise about how resources get spent and who decides upon those directions and specific allocations. These money issues can highlight how democratic the overall decision making process is, or expose its authoritarian tendencies.

❏ Money And Membership

If one of the major sources, or even one of the sustaining sources, of a coalition is participant fees, the money may limit membership in the coalition. As suggested in an earlier Tip Sheet , we propose a membership process that has no fees attached to it. There should be a coalition sponsorship process, which allows people to contribute on an annual basis, generally based on the size of their organization. Members of the coalition would include anyone embracing the coalition's mission and not be tied to paying a fee to join. This distinction between membership and sponsorship is helpful in making sure that dollars do not become a criteria for joining a coalition (For more on this, see Tip Sheet "Coalition Membership").

❏ How Money Can Help A Coalition

In spite of the above warnings, money can help a coalition. Core funding for staffing and maintaining the process and development of the coalition is critical for the success of most coalitions. It is our belief that, although unstaffed coalitions can be successful to some degree, the capacity of the coalitions to take on multiple issues over a long period of time and have a significant impact can be increased with paid, facilitative coalition staff. Thus, finding the resources to fund such staff is enormously helpful. Even a halftime staff person and secretarial support can be enough to move a coalition forward in a rapid fashion.
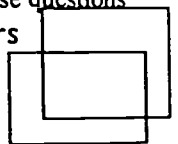
❏ Where To Find The Dollars

This, of course, is the million dollar question. The experiences of numerous coalitions across the country indicate that there are a variety of sources. Most larger coalitions have been developed around an initiative from state, federal or private sources soliciting coalition responses to issues such as violence prevention, teen pregnancy prevention, tobacco cessation, etc. Other sources of coalition funding include: a) sponsorship fees from members, b) community foundations, c) larger foundations and corporate giving programs, d) local cities and towns - especially through Community Development Block Grants and Small Cities Grants.

In sum, money can be a key force in moving coalitions forward or can be a major barrier to coalition success. The basic instinct to seek large amounts of dollars for coalitions should be tempered by a planning process that asks how much funding do we need? For what coalition functions? Who will decide how it is spent? Can we anticipate the benefits and the problems that funding might bring? It is only after coalitions have successfully asked and answered these questions that the search for funding should begin.

One in a series of tips on building coalitions.

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Sustainability Of Coalitions

by Tom Wolff, AHEC/Community Partners

❑ Sustaining the Effort

Sustaining coalitions over an extended period of time is a little-explored issue. There is very little literature, even anecdotal literature, on coalitions that have lasted over many years. What happens to these coalitions over time? What are the developmental stages and forms of long-standing coalitions? And what leads to the continued viability, and success or failure, of sustaining efforts?

In general, sustaining coalitions is like sustaining any other organization. It relies upon the capacity of the organization to be flexible and adaptive to changing environments and changing times. In coalitions, we would expect that the mission and goals would evolve over time, and that various task forces set up by the coalition would adapt to changing issues in the community. We would expect membership to keep changing, so that each year new people join, while others might drop out. Leadership would also rotate: In a healthy, long-standing, sustainable coalition, new leaders would constantly emerge and be given positions of responsibility — leading a task force, managing a special project, or chairing the coalition itself. The bottom line for sustaining a coalition, however, would be the same as that for any successful community venture; that is, the capacity to act and have an impact on the community. Our experience is that long-lasting coalitions keep on acting — visibly, energetically, and effectively.

❑ Sustaining Coalitions After the Funding Dries Up

The sustainability of coalitions has another key dimension, and that has to do with outside funding. One of the great dilemmas in human services for government and foundations has been how to go about seeding a new idea with money, and then sustaining that idea over time as funding draws to an end. We have all been involved in too many projects whose life is as long as the funding; projects which die when the funding disappears. So how can we sustain externally-funded coalitions? This Tip Sheet explores a fourfold approach. Each approach may be appropriate to different degrees, depending upon the coalition and the community's needs. Each carries with it some advantages and some disadvantages. In general, a mixture that employs all four strategies is most likely the soundest approach.

○ Fund-raising and Incorporation

The knee-jerk reaction of almost any project or coalition is to find new funding to replace the old. In this approach, sustaining the effort means finding another funding source. Thus, mature coalitions often write grant applications, throw fund-raisers, create membership schemes — all ways of generating new dollars. Incorporating the coalition as a 501(c)(3) non-profit organization and applying for tax-exempt status frequently go along with this, so that the coalition is in proper legal form to receive state, federal, corporate and foundation money. The rationale is simple — finding a new funding source will allow the successful coalition to continue its success. The advantage of this approach is that the coalition can continue to fund staff and programs it has created. The peril is that it is often seen as the only way to sustain the effort, and doesn't allow for considering other ways to sustain — ways which may involve greater community ownership and less professional management. With this strategy, the possibility increases that the coalition becomes just another community agency.

Fund-raising has its peaks and pitfalls. For a more through examination of this issue, see the March/April Tip Sheet: Money and Coalitions. It is my suggestion that this approach might be the last one considered, after looking at the following three.

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O **Institutionalizing Efforts**

In this strategy, the coalition supports efforts — or even better, <u>plans</u> efforts — so that each initiative developed could be incorporated into an existing community institution. For example, a coalition can begin an after-school program, and plan for the YMCA to pick up the program after a few years; or develop a school prevention program, with the goal of shifting its management to school health educators; or start a program to prevent homelessness, and work with an interfaith council to adopt it. In this strategy, the coalition's role is as catalyst; it acts to create innovations and change that can be adopted and institutionalized in other community organizations.

O **Policy Change**

Some coalitions have found effective ways to sustain their efforts through changes in rules, regulations, and laws of the community. By employing advocacy and social-change mechanisms that permanently alter policies, practices, and procedures within a community, these coalitions continue to fulfill their mission. Good examples of this can be found in anti-tobacco coalitions that worked to have boards of health change the laws and consequences of under-age purchase of cigarettes and tobacco products; or anti-drug and alcohol coalitions that work to create local keg licensing laws, to change practices regarding large parties where kegs of beer are consumed. Another topical example would be an AIDS coalition that successfully lobbies for condom distribution in schools. In these cases of policy change, sustainability occurs by incorporating change into the community's laws and regulations. Here the role of the coalition is as advocate for policy change.
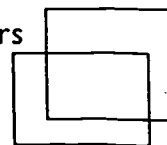
O **Turning To The Community**

The fourth, and most provocative sustainability strategy, is to turn over what the coalition has begun to the citizens in the community, using an approach stressing empowerment and community development. Here the basic premise, both in sustainability and also initial design, is keeping the coalition's efforts alive by having citizens own and lead the initiatives. Projects that focus on the development of citizen leaders are used to build the skills and capacities of individuals and organizations in the community. One such program is The Right Question Project (based in Somerville, MA), which helps low-income parents become monitors and advocates for their children's education. Sustainability occurs because individuals and home-grown organizations are better able to help the community solve its own problems. The role of the coalition here is as capacity builder.

With each of these four strategies, the role of the coalition differs. If fund-raising and incorporation is the dominant approach, then the role of the coalition can be that of another human service agency. If its strategy is institutionalization, the coalition's role is that of catalyst. If it's policy change, the role is one of advocacy. If it's empowerment, then the role is capacity builder. Ideally, as funded coalitions look to sustainability, which they hopefully will do when they start (as opposed to in the last twelve months of funding), they will use a mix of these four strategies and develop others to create the most effective way to sustain their efforts.

Yet possibly the most important sustaining force is the vital energy within the coalition — what we might also call its spirit. Coalition members should see themselves as keepers of the flame. If the flame dies down, if it becomes embers, it's much harder to keep going and to do good work. How to keep the flame, and fan it, is certainly the million-dollar question. A track record of success surely helps. So does modeling by the leadership, over and above routine management of functions. The bonds among the membership, the willingness to celebrate even small successes, will help as well. A coalition which can find ways of nourishing its own inner spirit will have a much greater chance of continued success.

One in a series of tips on building coalitions.
May/June, 1994

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Coalitions and Mini-Grant Programs

by Tom Wolff

❑Mini-grants - What Are They?

Mini-grants are small, one-time only, cash awards given to community groups and others for short-term community projects. More and more coalitions are using mini-grants to stimulate community action and increase the coalition's visibility, while broadening the audience for the coalition's work. Mini-grants are potentially powerful interventions that, when used effectively, engage citizens in coalition and community betterment efforts, and generate accomplishments citizens can take pride in.

❑Why Use Mini-grants?

Proper use of mini-grants has multiple community advantages;

1. They inspire innovative thinking. If necessity is the mother of invention, then small amounts of funding are the sister of creativity.

2. They are an excellent way to reach people we often call "the hard to reach" or "yet to be reached." Mini-grants are often awarded to groups (like parent-teacher associations, scouts, neighborhood organizations) that have access to many more citizens than traditional health and human service organizations.

3. They build political and community support, and bring new partners into the coalition's efforts. When money goes directly to the grassroots groups that people connect with regularly, coalitions sponsoring mini-grants become more visible as a positive force that really meets local needs.

4. The small amounts of money ($400 to $2,000 per mini-grant is a general range) tend to discourage large agencies from applying, while encouraging smaller, innovative groups who might not otherwise respond.

5. Mini-grant monies tend to buy products, not staff. In-kind contributions of staff time increase with mini-grant use. Having to make the money go a long way forces people to bring other resources into play, and increases the amount of matching and volunteer support projects receive.

6. Mini-grant projects are more easily sustained. Experience has shown that when it comes to mini-grants, people tend to think of durable and replicable projects. Puppet show scripts, demonstrations, conference materials, and curriculum kits have all been developed with mini-grant money.

❑Steps in Making Mini-grants Work

•Goal Setting

Once the coalition or community group allocates money (a good range is $4,000 to $20,000) to be distributed as mini-grants, it must set goals for the mini-grant program. The goals can be specific or general. For example, a traffic safety program wanted to increase seat belt use; it set seat belt promotion as the goal of its mini-grant program. In another case, a coalition, thinking more generally, set increasing community leadership as its mini-grant goal.

•The Application

Once goals are set, application guidelines and forms are issued. The application guidelines should describe the goals, the amounts available, the application procedures, the review criteria, any limitations on how the money can be spent

(for example, most federal dollars can't pay for advertising), and a description of the mini-grant program's sponsoring coalition or group. It should also give examples of mini-grant activities to get people thinking.

The application form should be no more than 1-2 pages, and should have three sections. In the first section, ask for such items as the applicant's name, address and organizational affiliation (if any). In the second section, ask for details about the project they are proposing for funding — who will be reached (target audience), what will be done and (brief project description); when, where, and why will the project be done. The final section should include a simple budget form for applicants to fill out. The overall application should use clear, easy-to-understand language (no "jargon") and be user-friendly. Hand-written applications should be acceptable.

•Outreach

Members and staff of the sponsoring coalition or community group should also be prepared to devote serious time to outreach, both in distributing and publicizing the application and in helping groups fill it out. Distribution to the grassroots community can include posting on bulletin boards, newsletters, newspapers and word of mouth. All announcements, fliers, and posters should make clear that the mini-grant program is for small grassroots groups like scout troops, theater groups, and block associations. To facilitate this process, staff should also be available to assist groups in developing ideas and filling out the form — getting ideas translated into an application. For example, a group of young people seeking funding for an after-school basketball league might need some help figuring out a budget.

•Making Awards

A committee should be established to review submitted applications. To insure impartiality, committee members must not be applicants for the mini-grants. The committee should review all applications with regard to a preset criteria, rank applications and suggest award amounts. To increase the number of projects funded, negotiating with applicants for reduced awards is often effective. Certain projects may also be combined in ways that maximize the available funds.

•Agreements

A short agreement between the awarding organization and the group receiving the mini-grant needs to be created and signed by both parties. It should delineate the responsibilities of both parties, including completion date and reporting requirements. As in the application, the language should be straightforward.
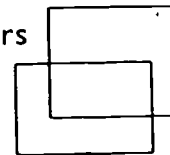
•Monitoring, Evaluation, and Technical Assistance

Most groups awarded mini-grants complete successful projects without much monitoring. It is, however, a good idea to "check in" every now and again with recipients. Brief status reports are beneficial because they do not create a heavy paperwork burden for citizen groups, but still keep everyone aware of progress toward the project's completion. These reports, along with a final report once the project is completed, also serve as an evaluation tool. Reports and a memorandum of understanding go a long way in keeping each party accountable and on track. Technical assistance provided by the awarding group or coalition can also help groups get started and stay on target with their projects, find resources, and assist if a group gets "stuck."

❑Additional Resources

• The Community Anti-Drug Coalitions of America Strategizer Series, "Coalition Mini-Grant Programs" is a brief "how-to" on mini-grant programs with additional details. Write to: CADCA, 701 North Fairfax Street, Alexandria, VA 22314, (1-800-54CADCA)
• "Putting It Together: The Safe Roads Success Story," a sampler of mini-grant programs related to safety belt education, can be obtained by writing: Robin Riessman, Safe Roads, 99 Main Street, Northampton, MA 01060. Ms. Riessman also contributed to this Tip Sheet.

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One in a series of tips on building coalitions.

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The Care and Feeding of Coalition Leaders

Coalition
Building
Tips

by Christine Driscoll, Neil Novik, and Tom Wolff

Coalition leaders play critical roles in sustaining the energy and direction of community coalitions. How do these leaders survive and grow? Having a job as a coalition coordinator or coalition leader is a new phenomenon. Ten years ago, one would have been hard pressed to find more than a handful in any state in the nation. Now, most states have dozens of people doing this work.

We have learned that the role of the coalition coordinator is an exquisitely complex one, involving numerous functions and a capacity to work with a wide variety of groups and individuals. Coordinators and leaders must be perceived as fair and able to deal with conflict; they must be able to help a diverse group create a vision and an action plan, and then move forward. In many cases, the role of coalition coordinator was created in response to a funding initiative. The coordinator's position, therefore, frequently does not sit within an organization with skilled staff to supervise the coalition leadership. Indeed, there are few skilled enabling systems to support coalition building, or other community initiatives as well.

Given this, what kinds of support should be provided for coalition leaders? What kinds of support should organizations offer when thinking about starting a coalition? Three types come to mind: administrative, fiscal, and supervisory.

☐ Administrative Support

Supporting community coalitions should include an administrative component. A support office should serve as the information hub and problem solving capital of its affiliated coalitions. Information, resources, and other types of administrative support should be readily available to coalition staff. Some examples of administrative support for coalition leaders might include:

■ Researching coalition-specific information. In our case, we've checked out the best kind of copiers to buy, plane fares to distant places, and even per-capita lottery spending

■ Sharing the news of one coalition's success with other connected coalitions

■ Creating speciality items using advanced technology, e.g., newsletter mastheads, brochures, meeting fliers

■ Assisting with the creation of bookkeeping systems

■ Providing a shoulder to lean on and "gossip center," enabling coalition staff to feel that they are part of a work community — connected, supported, and never alone

Support organizations might also have a full library of materials that expand on coalition building and community development, advanced technology (such as computers, fax machines and copiers), and a training capacity (on new computer software and technology, such as computer networks and e-mail). Sending out a packet of current materials (newspaper articles of interest, funding announcements, conference brochures and the like) monthly to all affiliated coalition members is another way administrative support can help coalition leaders.

Many of these administrative services are easily found within larger organizations; but to the single staff person of a coalition they can be elusive. Finding this support is possible, however. Looking to the lead agency for bookkeeping support, polling other members of the coalition to see what they can offer, and hiring a part-time or shared administrative assistant are all ways to get needed help.

❑ Fiscal Support

The lead agency can give fiscal support too. Its overall fiscal goal, especially when it is supporting more than one community organization, is to establish order out of potential chaos. This can be accomplished in several ways.

■ *Maintain flexibility without loss of accountability.* Establish procedures which give communities flexibility in how dollars are spent, but which maintain mutually-agreed-upon standards of accountability. For example, a coalition may want to establish a mini-grant program, and may need to provide funding to grantees in advance, because of the grantees' inability to front the money. The lead agency should be able to handle this request. At the same time, it is reasonable to expect the coalition to provide evidence of grantee monitoring and assurance that funds are spent appropriately.

■ *Appreciate the need for a quick turn-around of funds and the occasional "emergency" request.* Coalitions operate on a shoestring; frequently, community residents either depend on coalition money as income, or have paid for expenses out-of-pocket. In these circumstances, it is essential that significant delays in reimbursement be avoided. This sometimes means that the lead agency must advance funds to the coalition for prompt payment of these expenses. To have community people wait to be paid can alienate them from working with the coalition again.

■ *Provide adequate reporting in exchange for responsible spending.* Lead agencies should expect that community coalition spending be responsible — within budgets, on approved items, etc. In exchange, coalitions need comprehensive and regular reports on their spending patterns. The reports need to be clear and user-friendly; and lead agency fiscal personnel must be available to coalition people to answer questions, offer guidance, and clarify misunderstandings.

■ *Do not isolate the community organization from the larger fiscal issues which the lead agency faces.* Coalitions and community organizations should be aware of and sensitive to overall constraints and regulations of the lead agency, such as fiscal year-end and auditing requirements. Submitting expenses in October for the previous May, when the fiscal year ended in June, is an all-too-common, yet avoidable problem. Similarly, if the funding source has certain guidelines which affect community planning, make sure communities know about them. For example, if the funder will not pay for equipment, make sure communities know it; if there are preferred, or required, vendors, make sure they know that too.

❑ Supervisory Support

Another component of support comes from those in supervisory positions. Supervisory support to coalition leaders creates a collegial problem-solving environment where the coalition leader can bring large and small problems and find a welcome and helpful ear. Issues raised may include immediate, urgent crises, but also longer-term problems and future planning. The difficult role of coalition leader requires someone available to help the leader think through, clearly and fairly, the many difficulties that can arise and find a range of solutions. Supervision can also be a place for the coalition leadership to look into the future, to plan for accessing fiscal resources to keep the coalition alive and growing, and also to clarify and modify the coalition's mission, goals, activities, and vision.
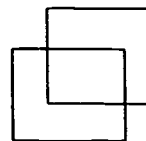
Supervision is also a place to tie coalition activities to the broader social environment, and to connect the coalition with additional resources and contacts outside the coalition area. The supervisor, for example, might make a linking phone call, or suggest a reading, or provide a framework from another discipline for the coalition leader's work.

Finally, supervision is also a place for the individual leader to examine his/her personal issues and how they impact the coalitions's work. These can be questions of style, time management, or conflict resolution.

In sum, at the heart of each coalition are one or more leaders who are critical to managing the coalition's development. The care and feeding of these coalition leaders are essential to the coalition's success.
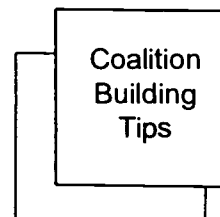
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What Coalitions Are Not

by Tom Wolff

There was a time when one of my adolescent daughters would respond to many a comment with the ubiquitous "NOT," popularized by Wayne and Garth of the movie "Wayne's World." Now, when I hear all sorts of people saying, "Our initiative is a coalition," often, my first instinct is to respond, "NOT" as well.

But simply to quash people's beliefs without benefit of explanation is, at best, unfair. So this seems like an appropriate time to revisit the question of what coalitions are, and what they are "NOT."

While it is heartwarming for those of us who have been in the trenches doing coalition building for years to see that coalitions are now a hot new trend in program development, it is also disconcerting to see many initiatives using the term but stretching it beyond recognition. So let's start bringing the term back into shape.

Coalitions are **not** externally run or externally driven organizations. They must have a strong base in the community. That base should have a strong citizen component; but even for a coalition of agencies, those agencies must have deep community roots.

Coalitions are **not** human service organizations. This is another common misconception. We see numerous coalitions that hire staff and run programs only to become the next mega-agency on the block. There certainly is a legitimate place for human service agencies, but they should not be confused with coalitions. Coalitions work best as catalyst to action, the more they become service delivery centers, the harder it is for them to focus on their role of catalyst for community change.

Coalitions are also **not** an automatic link to the grassroots and "real people." Too often people think that creating a coalition will naturally create links to the grassroots. But this is unlikely if, coalitions are composed of institutional representatives rather than citizens. Coalitions must make special efforts (such as having outreach workers) if they are serious about reaching the grassroots.

And finally, coalition building is **not** a cure-all. Even the most successful coalitions are often limited by their focus on trying to solve the local community's problems; but this does not provide easy answers to dealing with the numerous issues impacting that community from outside. As the new Congress and the Contract with America create havoc in our communities, we are only too well reminded of the need for coalitions to be able to act outside their own communities, on the state, national and ultimately international issues that have increasingly immediate effects on community life.

In addition, there are several noted commentators on the subject of what coalitions are not. A representative collection is added here for consideration.

The MacArthur Foundation's Collaboration Project identifies several misconceptions regarding collaboration. Collaboration is central to coalition building. The first misconception is that collaboration is efficient. A collaborative effort through coalition building is not necessarily efficient, nor always desirable. It involves casting a larger and larger net to involve more and more people in both identifying and solving a community's problems. This requires building consensus and building trust, both of which take time. Coalition building is not a "quick fix," nor a one year project.

The second misconception is that collaboration saves money. We have yet to see any data supporting that assertion. We do hear, implicitly and explicitly, the idea that addressing issues collaboratively is being sought predominately as a money-saving venture. Often the hope or intent is that collaboration will bring together a range of human service providers who will find a single entry system for delivering care that will reduce overhead and duplication of services. Although there are multiple benefits to coalition-building -- it can, for example, reduce duplication of effort -- saving money is not one of them.

The third common misconception identified by the Collaboration Project is that collaboration is the only way to deliver services. Again, it's clear that there are times when collaboration is the most appropriate intervention, but there are also times when it still makes sense for individual organizations, whether neighborhood associations or human service agencies, proceed on an initiative individually.

Another commentator on what coalitions are not is Dail Neugarten, the Executive Director of the National Leadership Institute on Aging. She first indicates that coalitions are not formal organizations. She suggests, rather, that coalitions are "more like orchestras composed of autonomous and talented people linked together by a conductor and by a score."

Neugarten also notes that coalitions are not expert systems. Coalitions may indeed have some experts, but coalitions succeed because of their capacity to follow a collaborative problem-solving process – engaging the community and critical stakeholders in an effort to identify the issues, brainstorm new solutions and implement them.

Her third comment on what a coalition is not is that coalitions are not stable or predictable. Anyone who has worked with coalitions over a long period of time knows this to be an ultimate truth. Coalitions, even at their best and most engaging moments, are filled with passions, egos, turf battles, and ongoing difficulties. It's wonderful to walk in the sun, but the next thunderstorm may be moments away.

Finally, she notes that coalitions are not ends in themselves, but rather a means to an end. And certainly we have seen many examples of coalitions that have either outlived their usefulness or never actually found it, but have instead become forums for endless planning and contemplation rather than forums for action. At its heart, coalition building is a mechanism that allows communities to solve their own problems more effectively . Too many coalitions don't get to that problem-solving phase.

It's difficult to write a Tip Sheet on a topic that sounds as negative as "What Coalitions Are Not," but the most recent surge in interest and expansion of coalition efforts requires us to be clearer than ever about what we mean by the terms.
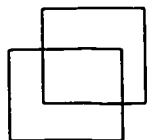
And let's end on a positive note. Coalition building, collaborative problem solving, and community development are some of the most effective interventions for change available to us today. Coalitions are partnerships of the many sectors of a community which gather together collaboratively to solve the community's problems and guide the community's future. When they are driven by citizen identified issues; citizens become involved in all steps of the problem solving process. Using this definition, coalition building becomes a powerful and enduring force for change.

References

MacArthur Foundation Collaboration Project, 140 South Dearborn Street, Chicago, Illinois 60603

National Leadership Institute on Aging, University of Colorado at Denver, 1445 Market Street, Suite 320, Denver, CO 80202

AHEC/Community Partners
24 South Prospect Street
Amherst, MA 01002

One in a series of tips on building coalitions.

Coalition Barriers and How to Overcome Them
(or Help! I'm trapped in a coalition and can't get out)
by Tom Wolff

Anyone who has been in a coalition will tell you that the path to success is a rocky one, often marked by two steps forward and one step back. This shouldn't surprise us! Many forces in communities and community helping systems are opposed to coalition building and community development. We must then think about the path of coalition progress as a dynamic one, one that is constantly changing with time. New obstacles (and opportunities) always keep arising. So let's look at some commonly- encountered barriers to coalition success, and outline some strategies that a coalition might develop to counteract them.

Barrier 1 – Turf and Competition

A clear and explicit goal of coalitions is often to promote coordination, cooperation, and collaboration. But it comes as no surprise that turf, territoriality, and competition among coalition members is a major barrier to coalition success. The capacity of one organization to feel competitive with another often amazes outsiders. This competition can be just among health and human service agencies as they compete for clients and contracts, but can also be between the private sector and the public sector, between local government and state government, or between local government and the community. A new request to provide a service might be issued by the state, and two or three different agencies – all members of the same coalition – might begin to compete for that contract, seemingly undermining the coalition's goal of cooperation. One would hope that having declared themselves wanting to be part of a coalition, these turf battles would decline – but they often escalate instead.

Strategies

In his community organizing work, Saul Alinsky always paid attention to the self-interest of all the parties, believing that solutions had to include attention to the self-interest of all. Too often we expect self-sacrifice from individuals and organizations as they move toward coalition solutions. If we understand that personal and organizational self-interest is part of the reality and part of what motivates people, then we can look for strategies that take self-interest into account. It is also possible to minimize the impact of turf, territoriality, and self-interest by appealing to a larger good. In our experience with coalitions, the larger and common good that has most appeal is that of the community and neighborhood. This is why coalition building often focuses on geographic areas.

Barrier 2 – Bad History

The most frequent comment we get when we come into new communities and talk about building a new community coalition is, "Oh, we tried that once before here. It doesn't work." Most communities have had unsuccessful attempts at building cooperation and forming coalitions in their past. Most frequently, these attempts were ill-fated because they did not involve a carefully-thought-out process, did not have enough resources to succeed, or were imposed from above as a mandate: "You WILL cooperate."

Conflictual histories also exist between agencies and different components in communities, and one should never forget their impact. Too often we enter communities without knowledge of context, thinking that history starts when we put our foot in the door. We should never forget the power of history. All we have to do is talk to an agency director and hear, "We don't work with that other agency because 15 years ago they had a director who insulted our director at a public meeting" to realize how important it is.

Strategies

The first strategy is to learn the community's history. Determine what efforts occurred in the past to build cooperation and coalitions, and how they succeeded or failed. One can also collect a detailed history of conflict and cooperation among agencies in the community. Following that, the second key way to undo bad history is to create an open and fair process that allows everyone to participate, everyone to set the ground rules, and everyone shape the coalition's agenda. In this way, some of the factors that led to conflict in the past can be avoided in this new round of coalition building.

Barrier 3 — Failure To Act

One of the most lethal behaviors of coalitions are endless, long-term planning meetings that bog down a coalition before it ever acts. Many of us have sat on coalitions that aim to solve problems by involving a large number of important people with busy schedules, who sit around a room for over a year thinking, planning, and doing needs assessments before anything happens. In most cases, this long planning process without action is not only unnecessary, but can also destroy a coalition before it starts. Administrators and bureaucrats are used to sitting in planning meetings; though the best of them have a limited tolerance. But citizens, citizen groups, and those in the community committed to change are often quickly turned off by such an atmosphere. Coalitions at their heart are based on creating change and demonstrating the capacity to act. It is this capacity that attracts the kinds of members who make coalitions succeed. When coalitions fail to display a commitment to action, or display a fear of advocacy, then they discourage the involvement of exactly the people who will make the coalition a success.
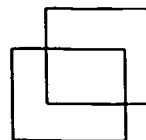
Strategies

Although a coalition must be able to operate in a planful manner, it must also be able to produce some actions and results in its first weeks and months of existence These are not opposing goals. One can be involved in a careful, long-term planning process, while at the same time acting on issues like creating a newsletter, circulating a petition at a coalition meeting, or holding a public session on a controversial topic. All of these can happen within the first months of a coalition's existence. Such actions show the members and the community that the coalition is committed to making something happen, as opposed to writing reports that sit on someone's shelf. In order to keep players in the coalition from the start, the coalition must be able to demonstrate a commitment to action and them it must indeed act. Both commitment to action, and action itself must be sustained throughout the history of the coalition.

Conclusion

This is the first of what will be a series of three tip sheets on coalition barriers and strategies to overcome them. If you didn't see your favorite barrier above – wait for the next installment, or call (413-253-4283), write (24 South Prospect Street, Amherst, MA 01002), or e-mail <HN1877@handsnet.org>. The Doctor is in.
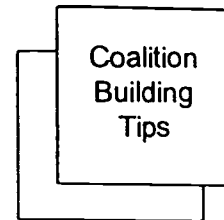
One in a series of tips on building coalitions.

AHEC/Community Partners
24 South Prospect Street
Amherst, MA 01002

Coalition Barriers and How to Overcome Them: Part II

by Tom Wolff

In our last tip sheet we began looking at the barriers and difficulties that can get in the way of a coalition reaching its goals. There are many of them. Here we continue this examination. We then identify practical strategies your coalition can use to overcome barriers and difficulties you may face.

☐Barrier #4 — Dominance by Professionals

Although key professionals in communities are often important members of coalitions and can be especially helpful assets, they can also become barriers. This happens when professionals dominate the process. Most members might then be professionals, the view of the community is generated only by professionals, and the control of the coalition is in the hands of professional agencies. Since many agencies view citizens and communities from a "deficits" point of view (see John McKnight's writings), they then bring this viewpoint to the coalition's work.

We see this kind of barrier in action, for example, when a group of adult service providers decides to deal with teen issues in the community by developing a teen center. In one actual situation, providers went about designing and opening a teen center without any input from the teens themselves. When no teens showed up in the first months, the professionals perceived the teens as being apathetic and blamed the teens for the problem. The providers did not recognize that only by consulting with teens, and letting them decide how best to set up the teen center, did they have any chance of success. This happens much too frequently — and not only with individual agencies, but with entire coalitions.

Strategies

Active attempts to recruit citizens are critical to coalition success. One should also respect the important role of "citizen helpers." These are people who have professional roles in communities, but who are also active citizens of the community, and therefore can wear both hats. Having citizen helpers does not eliminate the need to have citizen members who are not in a professional, formal helping role. Often, to get citizen input requires the coalition to actively go out in the community, talk to citizens, and test out new ideas before they are implemented. Unless the coalition is constantly asking the community what it wants and then responding to it, it will be hard to overcome the dominance of both professionals and professional "deficit" models.

☐Barrier #5 — Lack of a Common Vision

Increasingly, we are seeing examples of coalitions, often funded coalitions, where there is clear disharmony and disagreement around the coalition's goals. When these are funded coalitions, it is often the case that the original group that formed the coalition did so because they were attracted by the dollars, not by a common vision. This does not automatically rule out a common vision, but certainly creates a barrier to that process. In these situations, it is often a matter of "Take the money and run" rather than "We are here to create a joint vision and joint changes for our community." The existence and failure of these coalitions because of a lack of common vision potentially threatens the success of the whole coalition movement.

Strategies

Clearly, the most helpful strategy would be to develop a common vision before the onset of the coalition. Grassroots community coalitions typically have that; for example, the neighbors in the community all get together to make sure that the community playgrounds are safe. Where the joint vision has not emerged at the start, or dissolves quickly after the writing of the grant application, then there needs to be a clear planning process which involves visioning, revisiting the mission,

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clarifying the goals, and articulating objectives and action plans. This will help the coalition see whether there are indeed shared tasks that members wish to work on together. If there are not, the coalition needs to be brave enough to dissolve. If there are, the coalition can rewrite its mission statement and move forward. Coalitions are such vibrant and responsive institutions that this process of revisiting vision, mission, goals, and objectives needs to occur on a very regular, and at a minimum, annual basis.

❑Barrier #6 — Failure to Provide and Create Leadership

Coalitions have two leadership missions. One is to provide competent leadership for the coalition itself and for its tasks. The other is to create new leadership in all sectors of the community. Many coalitions struggle with one or both of these missions. There are coalitions where there is a lack of leadership — many lieutenants but no generals. The coalition then seems to flounder, not heading in any one direction nor accomplishing any one task. Often coalitions that manage to exchange information but never move forward to action suffer from the above difficulty. On the flip side, we see coalitions with a single dominant leader who does not delegate, who does everything him/herself. As with any other organization, we then find that the members or followers feel powerless, excluded, and increasingly less involved. One of the problems of bringing on coalition staff can be that these paid individuals take on leadership roles. The members can then easily say, "Well I don't need to do that, we'll let our staff person do it." The creation of that kind of staff role implicitly undermines the creation of new leadership roles among the members.

Strategies

Coalitions must consciously foster the development of leadership among all their members for coalition tasks, and also seek out new individuals to take leadership roles in the community. Leadership must be seen as multi-faceted and occurring in many ways — not just who runs the meeting, or who chairs a task force; but also who volunteers to get people to come to a meeting, who sets up refreshments, or who is the lead person behind the scenes making things work. Each of these are leadership roles. Coalitions must regularly evaluate how their organizations themselves are being led and how good a job they are doing at creating leaders.

❑Barrier #7 — Poor Links To The Community

The majority of coalitions seem to have little success in establishing solid links to the community as a whole. When coalitions begin with gatherings of human service providers or educators, the meetings that are scheduled are often inaccessible to working citizens in terms of time, space, and the language and culture of the meetings. Suppose a group of providers talks about funding sources coming from the state, using a variety of acronyms and initials; ordinary citizens quickly understand this is a world that they are not a part of; they may not return.
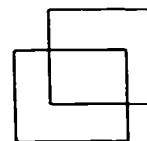
Strategies

Obvious strategies include not only making meetings more accessible in terms of language, time, space, and child care, but also having the agenda and process be citizen-driven. David Chavis has suggested that most of the basic institutions in our communities have become unaccountable to their citizenry; that the clergy is separated from its congregation, the schools from parents and students, the health and human service system from clients and patients. Rebuilding these links, and the accountability of the systems to the citizens, is a critical piece of coalition work.

In some ways, it seems that the major strategy here has to be an investment of funding into identifying and supporting and — if they are missing — creating citizen advocacy groups so that citizens can come to the table as representatives of constituencies like everyone else. In many communities, these citizen and neighborhood groups already exist. They should serve as equal partners. In other communities, funding and staffing may be needed to develop these groups and create that partnership.
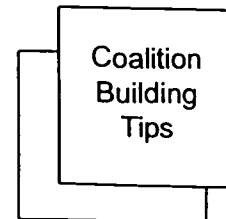
One in a series of tips on building coalitions.

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Healthy Schools, Healthy Communities:
The ABC's of Building a Partnership

by Debra McLaughlin and Gary Laszewski

Coalition
Building
Tips

More and more communities are working together to strengthen their schools. There is increasing recognition that if schools are supported in their mission to educate children, the community gains enormous benefits. These benefits include having well-educated children to address the needs of our changing society; better-equipped students to meet the challenges of obtaining higher education; increased employment opportunities; decreased poverty and truancy, and fewer risk behaviors such as smoking, and drug and alcohol abuse. This Tip Sheet will give some ideas on how to start a school-community partnership.

❑ Create a Planning Team

A planning team comprised of equal numbers of parents, principals or other school staff or officials, and representatives of community-based organizations should be formed. Members of health and human service agencies, houses of worship, service organizations, and businesses should also be considered when forming the planning team. In addition, the team should reflect the diversity of the community, both in terms of ethnicity and socio-economic status.

Equal representation is important so that one group does not feel "outranked" by another group on the planning team. The planning team is responsible for determining who else should be at the table, assessing needs and resources, and planning activities to address the mutual needs of school and community.

❑ Identify Local Needs and Resources

In order to determine the activities you want to work on together, it is essential to find out what is going on in your community. While it is important to find out community needs, it is equally important to determine your community's resources. And every community has resources, no matter how "impoverished" it might feel or is told.

There are low-cost or free ways to get data to help the planning team identify needs. Contact your local or county government office or library and request census data for your community. Census data can give you poverty and educational statistics, among other items. Check with your local United Way office, public health office, or community action agency for data as well. John McKnight's "Mapping Community Capacity" is one low-cost tool which inventories individual, neighborhood, and community assets. The identified assets can then be matched up with community needs.

❑ Choose Do-able and Measurable Activities

It is important for planning team members and the extended community to achieve success. The best way to ensure success is to develop activities that are well defined and where the expected outcome is very clear. This process is linked to developing clear goals and strategies to meet those goals. For example, the planning team may have a goal to ensure that children have something to do after school. The creation of an after-school program utilizing retired citizens in the community as teachers is an example of a strategy to meet the goal. In addition, the planning team can then determine how to identify the retired citizens, what subject areas they want to teach and where the after-school program should occur.

❑ Involve Parents and Families

Thirty years of research has shown that parent and family involvement improves students' learning. This is true regardless of the child's grade in school, whether the family is rich or poor, or whether the parents finished high school. Therefore, critical to the success of building a school-community partnership is 1) determining how parents and other family members can be involved in their child's learning and 2) participating in their child's school in a meaningful way. This includes parent and family involvement in hiring school administration staff, reviewing curricula, and shaping school policies.

❑ Get Technical Assistance

Creating school-community partnerships is a complex and evolutionary process. It takes time to build and nurture the

relationships necessary to making the school-community partnership effective. It can be helpful to identify sources of technical assistance to your efforts in order to determine how your planning team will make decisions, resolve conflicts, and set goals and priorities. Team-building exercises are also instrumental to developing a strong planning team that will guide the development of your school-community partnership.

❏ Put It In Writing

Once needs and resources have been identified, and activities have been proposed, put them in writing. These written components become the basis for your community's action plan. Planned activities should have goals and deadlines so your community can stay on target to address your identified needs. Every member of your planning team should get a copy of the plan. It can be circulated to local decision-making authorities such as the school committee, parent-teacher organizations, and parent councils, as well as to local media. The plan can also be an important tool in raising awareness and obtaining funding to carry out your activities.

❏ Keep Up the Interest

It is important to sustain the interest and energy of the planning team because no one has time to waste. Some suggestions: start and end meetings on time, be task oriented, brainstorm tasks for people who want to participate but cannot attend meetings (e.g. type up a flyer for events, write an article for a newsletter), have food and fun at your meetings, meet in someone's home, do a potluck supper. In general, keep the work enjoyable; if people, especially volunteers, don't enjoy what they are doing, they won't want to do it.

❏ Evaluate Your Progress

Contrary to popular belief and practice, evaluation can be simple, cost-effective, and fun. It is an opportunity to assess how things are going and also provides a way to make improvements during the course of your work. Market Street Research (see below) has created a straightforward method to evaluate your efforts.

❏ Celebrate Your Successes

It is important to document your accomplishments and celebrate them on at least an annual basis. This can be done at an annual meeting of your planning team, at an awards dinner, or at an open house. Make it fun and festive and share with each other and the greater community all that you have accomplished. You will be surprised at how much you can do!
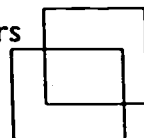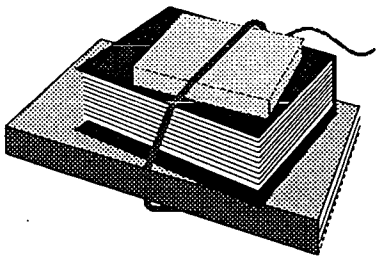
❏ Resources

There are many resources that may help get your partnership effort off the ground. Among the best:

1) From the Ground Up: A Workbook on Coalition Building and Community Development - A wealth of resources on the art of community development. Write: AHEC, 24 S. Prospect St., Amherst, MA 01002, (413) 253-4283.
2) School-Linked Services Manual - A handbook by the Massachusetts Executive Office of Education. Write: EOE, One Ashburton Place, Room 1401, Boston, MA 02108, (617) 727-1313, Attn: Gary Laszewski.
3) Right Question Project - An organization that promotes parent involvement teaching parents to support, advocate, and monitor their child's education. Write: RQP, 167 Holland Street, Somerville, MA, 02144, (617) 628-4070.
4) Institute for Responsive Education - An institution that researches and promotes parent and family involvement. Write: IRE, 605 Commonwealth Avenue, Boston, MA 02215, (617) 353-3309.
5) Mapping Community Capacity by John McKnight - A resource that helps communities build on their assets. Write: Center for Urban Affairs and Policy Research, Northwestern University, 2040 Sheridan Road, Evanston, IL 60201, (312) 492-3395.
6) Market Street Research - An organization that promotes user-friendly yet effective evaluation techniques. Contact: Market Street Research, 26 Market St., Northampton, MA 01060, (413) 584-0465, Attn: Liz Denny.
7) Together We Can: A Guide for Crafting a Profamily System of Education and Human Services. Write: U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328.

One in a series of coalition building tips.

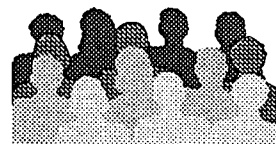AHEC/Community Partners
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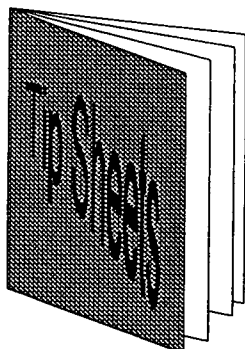
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Each of these information-filled sheets covers a single coalition building topic. They have appeared as a regular feature of our newsletter, now we have collected them for easy reference. Topics include: Principles of Success, Coalition Start-Up, Coalition Planning, Membership, What a Coalition Is Not, and more. $5, p.pd.
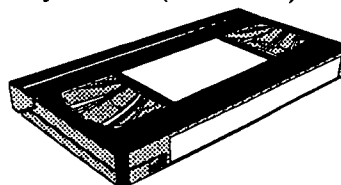
Now on video

Healthy Communities: An Overview
by Trevor Hancock, M.D., with Joan Twiss and Ted Landsmark
with a companion paper
by Tom Wolff, Ph.D.

This set provides an introduction to the healthy communities concept. Dr. Hancock, an internationally known consultant who has worked with the World Health Organization on its Healthy Communities movement provides a basis for understanding how to create a healthy community where you live. Tom Wolff expands on this issue in his companion paper, which focuses on Massachusetts and how healthy communities are being created here. $45, postage paid.
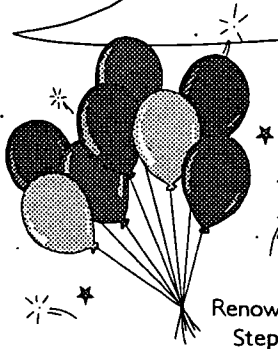
Community Hopes, Community Dreams with John McKnight

John McKnight, guru of the "community way," from Northwestern Univeristy, talks to folks at the 1992 AHEC/Community Partners annual conference. His approach to, and reproach of, human services will make you think. (60 minutes) $20, p.pd.

From The Ground Up...
A Workbook on Coalition Building and Community Development
Edited by Tom Wolff and Gillian Kaye

Renowned authors in the field of community development wrote the chapters for this book, they are: Stephen Fawcett, Ph.D., Beth Rosenthal, M.A., David Foster, Ph.D. and Vince Francisco, Ph.D. The editors, assisted by David Chavis, Ph.D, all nationally recognized in their field, are chapter authors as well.

Chapter titles include:
- Barriers to Coalition Building and Strategies to Overcome Them
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- Dealing with Conflict in Coalitions
- Community Assessment: A Key Tool for Mobilization and Involvement
- Monitoring and Evaluation of Coalition Activities and Success

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PAPERS AND REPRINTS

Coalition Building: One Path To Empowered Communities
by Tom Wolff, Ph.D.
Dr. Wolff explores coalitions that lead to healthy communities as their ultimate goal. Case studies and coalition building strategies are packed into 37-pages of highly readable prose. A true bargain at $10 per copy, p.pd.

Monitoring and Evaluation of Coalitions: Lessons From Eight Communities
by Tom Wolff, Ph.D. and David Foster, Ph.D. in conjunction with The Work Group On Health Promotion and Community Development at the University of Kansas, Stephen Fawcett, Ph.D., Director
This summary of AHEC/Community Partners coalitions' evaluation data serves as an introduction to the Work Groups' unique approach to coalition evaluation. $5, p.pd.

Coalition Building: Is this really empowerment?
by Tom Wolff, Ph.D.
A provocative self-assessment that asks if coalitions are truly committed to empowerment. $5, p.pd.

Building Coalitions That Work: Lessons From The Field
by Tom Wolff, Ph.D. and David Foster, Ph.D.
A summary of successes and lessons learned from the coalition building work of AHEC/Community Partners. $5, p.pd.

Community Partners Coalition Sampler

Actual coalition materials that you can modify and use for your coalition. Two hundred-plus pages of by-laws, policies, sample newsletter, resource materials, etc. $25, p.pd.

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Community Catalyst, $15 $_____

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Community Hopes, Community Dreams Video, $20 $_____

Coalition Tip Sheets, $5 $_____

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Building A Healthier Tomorrow

A Manual for Rural Coalition Building

KENDALL/HUNT PUBLISHING COMPANY
Dubuque, Iowa

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