Comprehensive Planning and Collaborative Action: 
Neighborhood Coalitions in Boston

by

Diana Markel 
B.A., University of Michigan 

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Signature of Author

Department of Urban Studies and Planning 
May 23, 1996

Certified by

Langley C. Keyes, Ford Professor 
Department of Urban Studies and Planning 
Thesis Supervisor

Accepted by

Mark Schuster, Associate Professor 
Department of Urban Studies and Planning 
Chair, Master in City Planning Committee
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Comprehensive Planning and Collaborative Action: 
Coalition Building in Three Boston Neighborhoods

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Abstract

In 1991, the City of Boston introduced the Healthy Boston Initiative. By promoting the formation of neighborhood coalitions, the initiative sought to overcome service fragmentation and increase collaboration across neighborhood organizations, institutions, and residents. Healthy Boston is typical of many comprehensive community programs currently supported by foundations and other public and private funding sources.

Given that many funders are increasingly asking for collaborative outcomes, but do not clearly define what collaboration means, I examined the experiences of the Healthy Boston participants to find out why people came together, why they stayed together, and how they think about what it is they are being asked to do. How do the people on the ground define collaboration?

I identified three levels of collaborative outcomes that occurred in the Healthy Boston coalitions. The first level is the formal programmatic outcome defined by Healthy Boston as the implementation grant. On the second level are the other “smaller” programs usually involving fewer participants than the implementation grant, and requiring less money if any at all. On the third are the elements that strengthen interpersonal relationships, what Robert Putnam refers to as social capital.

I found that coalition members came together for personal, professional, and institutional reasons. In addition to these reasons, they stayed together because of structural reasons such as well run meetings and because of level three collaborative outcomes including honesty and trust. People in the neighborhoods described collaboration, what Healthy Boston was asking them to achieve, as joint action, sharing resources, and sharing the credit for outcomes. However, they described creating an atmosphere of trust and honesty as critical to reach these collaborative outcomes.

Thesis supervisor: Langley C. Keyes
Title: Ford Professor of Urban Studies
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PREFACE

I was the Community Coordinator in Boston at the mixed income Harbor Point apartment community. One day, the director of the local health center called to say he received a letter from the City of Boston announcing a new program, the Healthy Boston Initiative. This program sought to rebuild community by bringing together health, human services, education, and economic development sectors in neighborhoods. The letter went on to say that grants would be awarded to community coalitions to integrate these sectors and develop “innovative approaches to improving their communities.”

Even with my cynicism of yet another initiative promising a new model that would change the world, I was always looking for more money and also truly interested in new ideas -- maybe there really was some program model out there that would make a difference. I did like the idea of Healthy Boston - bringing together all these sectors. It seemed obvious as a good way to proceed, but no one in my community ever had the time or energy to call the meetings and make it happen.

A conference formally announcing Healthy Boston took place in a high school auditorium, and the room was packed. We were told that if we were just there for the money, than we might as well leave. It was 8:30 a.m. on a cold, November, Saturday and that comment struck me as slightly disingenuous to a roomful to hard working tired community people. Of course we were there for the money, at least I was. If the money were attached to an idea that made no sense at all, I would not have shown. But a good idea backed by funding got me to that auditorium.
My community ultimately did apply for funding from Healthy Boston, and I became a coordinator of our coalition. As coordinator, I brought group of extremely different people with diverse interests to the same table and tried to figure out how I could keep them there. After almost two years, our coalition moved from an amorphous group with a general mission of improving the quality of life in our community to a coalition with working groups and specific projects in the areas of public safety, family support, and economic development.

I then went back to school, where I began to read more and more about comprehensive community programs that were the latest, hottest thing among certain thinkers in the urban planning and community development field. Foundation representatives and affordable housing advocates were talking about how community problems could not be solved by targeting only one area such as health, schools, or jobs. They described fragmented community services; the need to bring different neighborhood actors together; and that the community itself, inclusive of residents, agencies, institutions should decide on its priority issues and develop its own solutions. The comprehensive community initiatives hope that communities move beyond simply increasing cooperation, communication, and coordination. The initiatives use words such as coalition building, collaboration, community building to describe their goals.

Wait a minute, I thought, I have heard all this somewhere before. Healthy Boston was a model for exactly what these programs described. People were talking about how this
was a new way of thinking, and I was involved in a program that was already well underway. Healthy Boston and other funders created programs requiring neighborhoods to plan comprehensively and to collaborate. The funders described outcomes that would involve a number of different sectors working together, to develop programs and produce collaborative outcomes. They were less specific about what collaboration meant or how people were supposed to overcome the barriers between the fragmented programs. There was little discussion about what people had to do to create coalitions or what collaboration meant other than a group of people from different agencies working on the same program. There was also a disconnect between getting sectors and agencies to “collaborate,” and the individuals who have to make it happen. It’s fine for a foundation to say - hey - get over your turf issues, but this is not so easy to do for people with real concerns over funding for their agencies.

Most grant applications now, whether from a non-profit or the government, ask for evidence of community collaboration. Given that this is the current funding trend for urban neighborhoods, I wanted to talk to people who were doing it - to find what these program guidelines meant to the people at the ground level. How did they think about what the funders were asking them to do and how did they do it? This thesis is an effort to answer these questions.
Chapter I: INTRODUCTION

There has been a dramatic increase in the level of interest and funding opportunities under the guise of "comprehensive revitalization" or "service integration" in both the philanthropic and public sectors.¹

We are witnessing a renewed focus on comprehensive community based efforts in neighborhood revitalization and community development initiatives. Foundations, non-profit institutions, and government agencies that focus on and fund programming in urban areas are giving money to communities to promote comprehensive, collaborative planning efforts. Organizations coming from the different spheres of housing, social services, and health are also calling for more comprehensive efforts.

Comprehensive community initiatives are an idea in good currency. They promote a theory that individuals, organizations, and institutions, by joining together to identify problematic issues and develop solutions, will break down the barriers among them and achieve collaborative outcomes. The initiatives presume that collaborative outcomes are better outcomes. They are less clear, however, in describing how to break down barriers or what collaboration means for the individuals working in the agencies or living in the neighborhoods.

This thesis is about people in three Boston neighborhoods who implemented one particular comprehensive program - the Healthy Boston Initiative. The City of Boston funded neighborhoods to develop multi-sectorial coalitions to undertake a broad based planning effort and implement activities responding to priorities identified by the community. Healthy Boston's theory implied that collaborative programming is evidence of collaborative relationships. Given that many funders in addition to the City of Boston are increasingly asking for collaborative outcomes, but do not define what that means or how to get there, I examine the experiences of the Healthy Boston participants to find out why people come together, why they stay together, and how they think about what it is they are being asked to do. How do people working in neighborhoods define collaboration?

Healthy Boston

Healthy Boston developed in response to a view that services in neighborhoods and neighborhoods themselves are fragmented.

The existing systems of service -- from medical care to education -- are not designed or funded to work together to meet all the needs that people have. Nor are neighborhoods and communities as cohesive as they once were, supporting people and families in the normal course of their lives.\(^2\)

Defining health broadly to include "the economic, social, mental, and physical well being of people and communities,"\(^3\) Healthy Boston promoted the development of self-

\(^3\) Ibid.
identified neighborhood coalitions, while simultaneously improving coordination among city departments.

Healthy Boston defined coalitions as:

While not necessarily a legal entity, the coalition must be structured organizationally to be the decision-making and policy-making entity. It must develop a set of operating procedures that defines its leadership, membership, voting rights, committee structure and organizational activities. It must also develop recruitment and outreach strategies to assure that the coalition reflects the community diversity and involves all sectors in its activities. Each coalition must have a fiscal agent ... Each coalition must have the services of a coordinator to staff the coalition and carry out its work.4

A coalition, therefore was a formal neighborhood structure bringing together the fragmented sectors of economic development, education, health, housing and human services.

A coalition is a mechanism to channel the organizational interests of its members to meet the needs of individuals, families and communities. It is also a mechanism to include the wide diversity of groups who reside in or serve a particular community.5

Coalitions were the mechanisms by which neighborhoods would achieve collaborative outcomes. Healthy Boston, however, never clearly defined collaborative outcomes other

than to indicate that they involved a number of sectors that did not usually work together. To provide content and texture to the concept of collaboration, I identified three levels of collaborative outcomes that Healthy Boston coalitions produced. Levels one and two are programmatic outcomes, and level three encompasses relationship outcomes.

Level one is the formal programmatic outcome defined by Healthy Boston as the implementation project. This is a large scale program developed by the coalitions and submitted to Healthy Boston for funding. Level two is the other “smaller” programs, usually involving fewer participants than the implementation grant and requiring less money if any at all. Some are formal projects of the coalitions, other are more informal results of connections made at coalition meetings. On level three are the non-programmatic, “informal” outcomes which are relationship outcomes. The relationship outcomes are not new programs, but elements that strengthen interpersonal relationships such as trust and honesty. Although Healthy Boston awarded funds for collaborative implementation programs, implicit in its normative view of collaboration was the building of up relationships on the third, informal level. I use levels to distinguish among the three types of collaborative outcomes, not to imply a progression from one level to the next. For example, a level one outcome may not be the most important programmatic outcome for a coalition.

Many terms are used, sometimes interchangeably, in Healthy Boston and in discussions of all comprehensive community efforts. For the purposes of this thesis, I define the terms in the following manner:
1. **Coalition** is defined by Healthy Boston as a formal structure, representing a number of sectors in a self-defined neighborhood, with operating procedures and a coordinator.

2. **Comprehensive** means approaching neighborhood problems holistically. It recognizes that neighborhood problems have a number of roots and calls for all the organizations, institutions, and individuals who live and work in neighborhoods to jointly identify problematic issues and solutions.

3. **Communication** is the first step in increasing the flow of information in a neighborhood. It begins to happen when people meet each other. It is also referred to by coalition members as “networking.” It means that if you have a question, you know who to call.

4. **Coordination** refers to agencies avoiding duplication services or assisting one another’s activities. Coordination involves action around already existing activities. Healthy Boston hoped that coordination would result from interactions in coalition meetings. For example, two youth programs might have activities at the same time and could coordinate so that their activities did not overlap.

5. **Collaboration** describes both program and relationship outcomes where people work together, and no single individual or agency is rewarded separately. On an agency level, collaboration means creating new programs in which no one agency benefits. It implies trust and honesty on a personal level.

The relationship among these words is that coalition is a mechanism of organization, comprehensive is a way to look at problems and communication, coordination, and collaboration describe a continuum of relationships with collaboration at the “highest” end. For purposes of this thesis, the key word is collaboration because that is what Healthy Boston asked people to do. Communication and coordination are steps along the way, stages of intensifying relationships, before reaching collaboration.
To explore these concepts, I begin by reviewing the current comprehensive community efforts from three perspectives: community development with roots in housing, comprehensive community initiatives with roots in social services, and international public health. Although Healthy Boston is most closely linked to the international public health movement, this review highlights the commonalities among all these perspectives. I then outline the development of Healthy Boston guidelines to understand what the developers of the concept envisioned. I use the development and implementation projects of three Healthy Boston coalitions to set the context for the ensuing discussion of why people in the coalitions came together, how they maintained the coalitions, and how the people in the coalitions define collaboration -- how do they define what it is that they are being asked to do. Healthy Boston is one example of a number of current efforts that ask neighborhood agencies to collaborate. Through this thesis, I look at what this means for the people working in neighborhoods.
Chapter II: THE CURRENT EFFORTS CALLING FOR COLLABORATION

The theory behind the current comprehensive community based efforts is that poverty alleviation and community revitalization efforts should be approached holistically in terms of who is involved, how the problems are defined, and what the outcomes are. All the organizations, institutions, and individuals who live and work in neighborhoods must work together to jointly identify problematic issues and develop solutions. Barriers across these groups will be broken down and collaborative outcomes, and collaborative outcomes and relationships will be built.

These initiatives are comprehensive in that they are "holistic and integrated" efforts, neighborhood based because they focus on a specific geographical area, and community based because they define community empowerment as both a process and an outcome. For example, the principles behind the Ford Foundation's Neighborhood and Family Initiative focus on the:

interrelationships among social, physical, and economic development,
which have historically been treated as separate spheres of action ...[and]
the active participation, in both planning and implementation, of residents and stakeholders in the neighborhood targeted for development.

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Calls for new efforts in comprehensive planning are coming from at least three perspectives: (1) the community development corporation (CDC) movement with its roots in housing, (2) the comprehensive community initiative (CCI) movement with its roots in human services, and (3) the international public health sector’s Healthy Cities movement. These perspectives converge on a set of common assumptions about two elements encompassed by these new strategies. The first is the need for resident leadership and capacity building in the planning and implementation of programs. The second is the importance of breaking down barriers across the traditional agency and sector approaches to attacking poverty by building up relationships among neighborhood organizations. Because I am interested in collaboration, I am focusing on the second component.

Healthy Boston picked up on many of the issues in the CCI’s, CDC, and Healthy Cities movements. All are reacting to a narrow, fragmented approach by the agencies, organizations, and systems working in a neighborhood and to the lack of community control. In response, these movements call for:

- A recognition of the link between housing, economic development, schools, health and other sectors that play a role in neighborhoods
- The building of collaborative relationships among neighborhood residents, institutions, organizations, non-profits, service providers, and businesses
- Resident empowerment
- A focus on service integration and coordination
• Residents and neighborhood organizations and institutions working together to develop a comprehensive neighborhood plan.

Healthy Boston, looking at community development through a health lens, picked up on these same points and emphasized that health is a comprehensive issue and current systems are not designed to work together.

These needs, though often defined separately, are really interrelated: an individual who is homeless is less likely to find employment; a child who is hungry is not likely to perform well in school; a parent who cannot read is more likely to have a child who is unhealthy. Individuals and families often need multiple, coordinated services to see them through, and the existing health, human services and education systems are not designed in that way.8

To address this, Healthy Boston envisioned neighborhood coalitions that would both improve collaboration in neighborhoods and empower residents. The coalitions would:

be designed for community building and empowering residents, as well as for improving the coordination and integration of services that are delivered in the community. Coalitions should not be designed just for institution building and supporting service providers.9

The CDC, CCI, and health perspectives reflect current thinking “in the field” and set the context for the Healthy Boston Initiative. In the following, I set out the basic

IIA. The CDC Movement

Community Development Corporations (CDC) are well known for their efforts to build affordable housing. While the movement originated in a comprehensive approach to neighborhood development, its focus shifted over time toward the more quantifiable objective of housing development. Today, there is a call within the movement for a return to a more comprehensive approach -- what the literature refers to as community building. The definition of community building now emerging from the housing movement calls for "a heavier emphasis on increased resident involvement and institutional collaboration." One example of the "new" thinking in the community development movement is evident in Bill Traynor's call for a new community development paradigm and is exemplified in the Local Initiative Support Corporation's (LISC) Community Building Initiative.

CDC's grew out of a community based, comprehensive movement to break down the barriers across public and private programs to revitalize urban neighborhoods. One of the first CDC’s, the Bedford-Styvesant Restoration Corporation, developed out of the efforts of a coalition of grass roots organizations trying to:

attract municipal support for a comprehensive and integrative approach to the renewal of the community and discouraged the acceptance of the

segmented renewal and social programs that were being offered to the community.\textsuperscript{11}

Due in part to changes in funding sources, CDC’s moved away from broader development strategies and toward production of houses.

The resulting emphasis on quantifiable (principally “hard”) products has resulted in a de-emphasis of qualitative (principally” soft”) projects and programs. The de-emphasis has led to a shelving of strategies to integrate social, physical, and economic activities.\textsuperscript{12}

Bill Traynor echoes this vision as he identifies a community development movement that has become narrowly focused on the production of housing and “relies on highly skilled technical/professional expertise and is largely disempowering for community residents.” This focus, or what Traynor calls the “technical/production paradigm” led the community development movement away from its roots to empower poor people to change their own neighborhoods.\textsuperscript{13}

Traynor, arguing that the community development movement needs a new way of thinking, describes an “empowerment/consumer planning paradigm” that uses much of the language of comprehensive community initiatives and Healthy Boston. In this paradigm, “the fundamental activity is resident-led organizing and planning to create a

\textsuperscript{12} Shiffman and Motley, p. 7.
\textsuperscript{13} William Traynor, “Community Development and Community Organizing,” Shelterforce. March/April 1993, pg. 5.
comprehensive neighborhood agenda and a broad based constituency and leadership group which will advocate for that agenda.”¹⁴ Traynor calls for community building that “recognizes the multiple linkages between housing and economic development and [efforts at] ‘social development.’”¹⁵ His definition of community building implies that neighborhoods must cultivate relationships across fragmented sectors.

An example of a recent effort from the housing sector is the Local Initiatives Support Corporation’s (LISC) Community Building Initiative (CBI). LISC is a national intermediary that raises funds from private corporations and foundations and distributes the funds as loans or equity to community development corporations (CDC’s). LISC traditionally focused on housing. Its CBI initiative, however, is an example of encouraging CDC’s to look at broader social and community building issues as well. CBI’s goals include:

- engaging residents in defining problems and identifying solutions
- resident led needs assessment and priority setting
- building and fostering relationships between CDCs and public and private human service providers and institutions
- financing the construction or rehabilitation of community facilities that strengthen the social fabric of neighborhoods and provide centers for the provision of necessary services.¹⁶

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These goals are virtually indistinguishable from Healthy Boston except for using CDC’s as a focal point and the goal of building community facilities. Much of the language describing the process is also the same. CBI speaks of fostering:

broad collaborations among community organizations and public and private institutions ... Grant dollars will be used first to support a resident driven planning process (facilitated by a consultant if necessary); and then hire CDC staff to implement program priorities arising as a result of planning.\(^1^7\)

To implement CBI, LISC will provide up to $540,000 in grants over three years to citywide CBI sites. The city must provide matching funds. These CBI funds will support an average of four CDC’s in each city over a three year period. Examples of emerging CBI efforts include:

- A collaborative program that will focus on youth and families in Chicago. Elements include an arts focus for youth, development of tenant organizers, and youth employment.
- A focus on block club associations to rebuild the human, social, and physical capital of Kansas City’s urban neighborhoods.
- A collaborative effort called the Health Sector Initiative in Los Angeles that developed out of a planning effort to link growth industries with low income communities.\(^1^8\)

These local CBI efforts are moving beyond housing and working to collaborate with other sectors.

\(^{17}\) "Voices from the Field," Attachment, unpaged.
\(^{18}\) "Community Building Initiative," unpaged.
IIB. Comprehensive Community Initiatives

Comprehensive Community Initiatives (CCIs) acknowledge that they build “on the conceptual foundations” of earlier programs concerned with urban areas such as the Gray Areas program, the CDC movement, and Community Action Programs. From these programs, they borrow the concepts of comprehensiveness, coordination, collaboration, and community participation in order to work on poverty alleviation. However, CCI’s also developed as a reaction to the recent practice of social welfare and economic development fields that responded to the community building challenge in “piecemeal, categorical approaches.” CCIs want to develop new “comprehensive” efforts that:

- cross sectoral and programmatic boundaries and attempt to build on the interconnections among economic, social, and physical needs,
- opportunities and circumstances.\(^\text{19}\)

CCIs, like the CDC movement and Healthy Boston, see themselves as distinct from efforts that simply focus on services integration because CCIs “view residents and the local institutions as agents of change.”\(^\text{20}\)

The core principles of CCIs are comprehensiveness and community building. Community building focuses on “strengthening the capacity of neighborhood residents, associations, and organizations to identify priorities and opportunities to work together.” Comprehensiveness is defined as examining the broad range of people’s needs and looking at the connections among these needs.

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\(^{19}\) “Voices from the Field,” pg. 4.
\(^{20}\) Ibid., pg. 14.
The principle of comprehensiveness calls for constant consideration of systematic connections among issues.21 Collaboration is both the programmatic and relationship outcomes of looking at neighborhood problems comprehensively.

The Ford Foundation’s Neighborhood and Family Initiative (NFI) is an example of a CCI. Its four fundamental operating assumptions are:

1. work from a local base
2. build inclusive partnerships
3. take a comprehensive approach
4. emphasize community empowerment.22

Ford selected four cities each with a community foundation to implement NFI. The community foundations then chose both a neighborhood to receive NFI funds and the members of a collaborative which would be the “organizational force” behind the initiative. The grants to each neighborhood included $125,000 for planning and $1,000,000 for initial implementation. Part of NFI’s strategy calls for:

planning programs around “strategic points of intervention”; that is, those programs that link activities in different issue areas.23

This approach to “forced collaboration” shows up as a way to build relationships and again illustrates the prevalence of the idea that cross sector solutions are better solutions.

21 Ibid., pg. 5.
23 Eisen, pg. 35.
The Ford Foundation’s deputy director responsible for NFI, Prudence Brown, stated that NFI was different than other approaches that only coordinate services because of NFI’s goals to:

- bridge human services and physical revitalization
- build connections among programs so that their work adds up to more than the sum of their parts
- enhance neighborhood leadership and mobilize broad community support.24

The second point above emphasizes the collaborative nature of NFI and points out how the funders envision creating something beyond just coordination with these initiatives. This language is virtually the same as the language of LISC’s CBI program.

**IIC. Healthy Cities**

Initiated from a public health perspective, the Healthy Cities movement identified similar concerns to those raised by CDCs and CCIs -- services conceived and delivered in a fragmented manner and the need for resident empowerment.

The origins of the Healthy Cities movement lie in the Alma Alta international health conference which took place in 1978 in the former Soviet Union. The conference, sponsored by the World Health Organization and the United Nation’s Children’s Fund, was attended by representatives from “almost every country in the world.” Emphasizing

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24 Ibid., pg. 33.
both the need to act comprehensively and to involve the community in public health and anti-poverty programs, the conference:

underscored the link between health and other sectors including housing, industry and employment, education, and water supply and sanitation. The conference participants agreed that multi-sectorial approaches which emphasize community involvement can alter the socioeconomic environment and improve the health of populations.25

The Healthy Cities project lays out the following strategic goals:

- make health issues visible and political at the local level
- seek formal advocacy of health on the social and political agenda of city government
- break down barriers between municipal departments so that health becomes a serious objective of the entire municipal government and the community has a say in how to promote health objectives
- make the inevitable interaction between people, lifestyles, and environment an interaction for health instead of a threat to health.26

Led by the European region of the World Health Organization, as of 1991, there was network of twenty-five healthy cities around the world. Today there are “healthy cities” in Canada and Europe and a growing movement in the U.S.

The Healthy Boston program, although not developed directly out of Healthy Cities, is closely identified with its goals of approaching health and poverty comprehensively and

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promoting resident empowerment. An international health conference held in Boston in 1991 directly influenced the Healthy Boston model.

In sum then, the new paradigm in the CDC movement, the CCI’s and the International Healthy Cities movement are all reacting to the narrow focus of individual organizations, barriers across agencies, and a recognition that residents are not involved. Healthy Boston is one example of a program attempting to respond to these issues.
Chapter III: THE HEALTHY BOSTON INITIATIVE

Healthy Boston is an initiative to encourage collaboration among agencies, institutions, and residents in Boston's neighborhoods. Judith Kurland, Commissioner of Health and Hospitals in 1990, developed the concept to counteract what she saw as a fragmentation of neighborhood services and a lack of community control over resources. Kurland envisioned a program in which neighborhoods would come together, define their own priorities, and develop their own solutions. As introduced to the neighborhoods in 1991, the initiative offered funds to build a coalition, develop a comprehensive neighborhood strategy, and develop collaborative programming.

There are two groups of players in Healthy Boston -- the central staff in City Hall and the participants in the individual neighborhood coalitions. In the following discussion of the origins of the concept and the development of the program, I will use the name Healthy Boston to refer to the guidelines and funding coming from the Healthy Boston central office. When I discuss Healthy Boston in the neighborhoods, I will talk about individual Healthy Boston coalitions.

Similar to the comprehensive movements described in Chapter 1, Healthy Boston stresses resident capacity building and breaking down sectorial approaches. In this chapter, I outline how Healthy Boston moved from a concept to an initiative and what the initiative looked like.
IIIA. Development of the Healthy Boston Concept

Judith Kurland developed the outlines of what would eventually become the Healthy Boston Initiative. According to Kurland:

> It was an easy idea when you’ve worked at the Federal level and come from a progressive 60’s standpoint that it is OK to spend money and that the Federal government can solve problems. 27

In the 1960’s and 1970’s, she worked at the Federal level helping to pass the programs that were supposed to solve the urban problems that, she noted, still exist today. She also worked at the state level trying to ensure that the state received both funding and flexibility from the Federal government. She cites these experiences as critical in the formation of the Healthy Boston concept.

In the 1990’s, Kurland found programs serving Boston’s neighborhoods failing, not because of ill will or insufficient resources, but for a number of other reasons. The programs were “top down,” in that they were developed in centralized institutions, not by the people or the communities who would be using them. The programs were also fragmented. Different departments in city government may have been working on the same issue or providing similar services in a neighborhood, but were not in contact with one another. Kurland pointed out that “X’s are providing resources for Y’s.” Groups developing, implementing, and using the programs did not necessarily control the resources for that program. Finally, she noted that the changes resulting from efforts to

27 Interview with Judith Kurland, former Boston Commissioner of Health and Hospitals, April 12, 1996.
improve programs often led to more rigidity and less creativity. She tried to address these issues -- flexibility, creativity, bottom up planning, and control of resources -- in the Healthy Boston initiative.

Two other factors, her position and her location, added to her development of the concept. As Commissioner of Health and Hospitals, she felt she was in a place to bring the government and private sector together, a union necessary to carry out the Healthy Boston plan. She also judged that Boston was a city rich in programs, resources, and neighborhood organizations. Therefore, the idea was right, and she was in a position in a city where she felt she could implement it.

As Kurland developed the concept, she knew from the beginning that she wanted to bring city departments together and work with neighborhood organizations. According to one employee of Health and Hospitals working with Kurland, at this time there was no money set aside and nothing driving the effort except for the vision of Judith Kurland to move institutional resources into the community and involve residents more formally. 28

Kurland hired two employees to help her develop the concept into a program. They were instrumental in developing a model based on their own experiences in domestic community health and international health. The early Healthy Boston documents, produced largely by one of these early employees, focused on the “interplay between

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28 Interview with Jerry Mogul, Operations Manager, Healthy Boston. April 5, 1996.
communities and service providers."\textsuperscript{29} The Healthy Boston Initiative that finally emerged included more community building activities and broadened the scope of the project beyond involvement of traditional human service providers. The author of the early blueprint attributes this shift in large part to a conference on international health sponsored by the Department of Health and Hospitals. Held in April 1991, the conference entitled \textit{Building Health Through Community: An International Dialogue}, brought together community leaders, health and human service providers, academics, policy makers, and public officials from around the world "to share ideas about improving health and well-being here."\textsuperscript{30}

Judith Kurland cited this conference as a "turning point" because it helped broaden the concept of health.

There were over two hundred community organizations there including schools and tenants. Bringing in international examples helped to make it clear that the concept was not just about health care in terms of health insurance or access to health care, but also about economic development and job training and violence -- that all these issues also affect health. This was a difficult point to make because I was the Health Commissioner. The conference helped to broaden it.\textsuperscript{31}

Kurland’s concept fit clearly into the Healthy Cities movement begun in Alma Alta. As the speaker of the keynote address stated:

\textsuperscript{29} Health Challenge Boston: Towards a Blueprint for Healthy Communities. April 5, 1991, p. 3.
\textsuperscript{30} "Building Health Through Community: An International Dialogue," pg. iv.
\textsuperscript{31} Kurland interview.
The Healthy Cities' strategy emphasizes a frontal attack on poverty. It recognizes that urban health and economic development are inseparable and that, to be sustainable, the fruits of that development must be equitable. ... It is dependent on the level and quality of human services, on the cohesiveness of community services, and on the active participation of neighborhoods in decisions affecting community health.\textsuperscript{32}

At this point, a group of individuals from different departments within Healthy and Hospitals were working on Healthy Boston. They incorporated recommendations developed by participants from the conference and began to shape an initiative with a focus on improving service delivery and empowering communities by bringing together neighborhood organizations, institutions, and residents.

Looking for a mechanism to bring this process to the neighborhoods, the group decided to use community coalitions. The coalition concept was based, in part, on the previous work of some of the groups members in community health. Healthy Boston wanted coalitions that were representative of multiple sectors such as education, economic development, housing, and health care and therefore not issue or problem specific. Kurland liked the idea of coalitions because she knew Boston as a city where people were already organized, but usually around a single issue. She wanted to see different groups working together, recognizing the links across their issues. Given that so many community based organizations already existed, it seemed natural to bring them together through a coalition where they could look at more than one issue. She also hoped that

\textsuperscript{32} Knouss, pg. 3.
coalition structure would help so that one organization did not dominate. Finally she saw a duplication of services at the community level and felt that working together in a coalition would help others see that.

Once they adopted the coalition model, those who developed the Healthy Boston concept then had to decide what form the coalitions would take. Whether or not to use lead agencies was a concern. In Boston, there were obvious potential lead agencies in each neighborhood such as community health centers, Action for Boston Community Development, Boston Against Drugs, and Boston Community Centers. Again, the group members came up against their commitment to community empowerment and asked themselves - who are we to decide. They concluded, “Let each community decide.”

They also wanted coalitions that were not dominated by agencies and included resident, non-service providers and businesses. They decided on a “fiscal agency model” where there would be no designated lead agency, but one agency in charge of coalition finances. Healthy Boston deliberately limited the overhead that the fiscal agent could charge, so that no one would feel that the fiscal agent was benefiting.

IIIB. Introduction of the Healthy Boston Initiative

Through the work of Kurland, Health and Hospitals employees, city department heads, and an advisory board of community leaders and academics, Kurland’s concept became the Healthy Boston Initiative and was introduced as:

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33 Mogul interview.
A bold initiative by the city of Boston to improve the health of the city, its neighborhoods and its people by recognizing the power of communities and residents, restructuring the delivery of services, and creating a multi-sectorial partnership for change.

With its motto: "It takes a whole village to raise a child," Healthy Boston promoted the creation or development of neighborhood coalitions on one level while simultaneously improving coordination among city departments. Neighborhood coalitions, with membership from the economic development, health, human services, education, and housing sectors were the "building blocks" of Healthy Boston. Neighborhoods defined their own boundaries and were required to have at least one member organization from four out of the five sectors. These neighborhood coalitions would then apply for planning grants to “design a plan to integrate their services and to develop innovative approaches to improving their communities”

Recognizing that different neighborhoods were at different levels of organization, the City asked neighborhoods to define themselves as being in one of four levels of development: unformed coalitions, coalitions-in-formation, recently formed coalitions, or existing coalitions. Unformed coalitions and coalitions in formation could receive technical assistance grants and then apply for planning grants at a later date. Recently formed coalitions could receive up to $60,000 for an eleven month planning period. Existing coalitions could receive up to $30,000 for a seven month planning period. The

34 Public safety was added at a later date. Participation by religious and cultural institutions was also encouraged.  
Healthy Boston guidelines for what the coalitions should look like at the end of the planning period included:

- Represent all relevant sectors in the community\textsuperscript{36}
- Reflect the diversity of population groups who live there
- Be structured organizationally to be the decision-making and policy-making entity
- Have a fiscal agent
- Have the services of a coordinator to staff the coalition and carry out its work
- At least one-third of the membership must be from organizations of residents or community members which are not service providers
- At least one member of the coalition must be a public or private institution which has committed to contribute additional resources to the coalition’s planning or implementation activities.\textsuperscript{37}

Healthy Boston outlined required activities for the planning period, These activities varied depending on a neighborhood’s stage of development, but the overall requirements were:

- to form an effective coalition, inclusive of community interests and with an organizational structure that is functional and is accountable to its membership
- to produce an action plan, based on an assessment of community resources and needs, that demonstrates how coordination of existing

\textsuperscript{36} As long as the required Healthy Boston sectors were represented, the neighborhoods could decide for themselves what was relevant.

\textsuperscript{37} Healthy Boston Initiative, “Building Community Coalitions: Pilot Planning Grant: Overview A.” pg. 6-7.
services will be improved and that identifies the need for additional resources

- to conduct a special project or event (for recently formed coalitions only) demonstrating collaboration among coalition members and sectors and involving community residents\(^\text{38}\)

- to enter into a cooperative agreement with city agencies and other participating public and private funders or providers to work together to meet the needs of the community\(^\text{39}\)

The first operational task was, therefore, to form a coalition. Implicit in Healthy Boston’s theory was that bringing people together in a formal coalition would “force” them to work together and produce first, second, and third level collaborative outcomes.

By the end of the planning period, the coalitions would produce an action plan that to serve as the “the coalition’s comprehensive strategy to improve the quality of life for community residents.”\(^\text{40}\) Healthy Boston’s description of the action plan captures the essence of how Kurland hoped Healthy Boston would affect neighborhoods.

The plan developed by the coalition should recognize the relationships between the health of a community and its housing, education, economic status, and human services. The plan should emphasize community empowerment and capacity building and should make use of existing community networks. Most importantly, the plan should create a structure

\(^{38}\) At this point, Healthy Boston was not more specific about what collaboration meant.


\(^{40}\) Ibid., pg. 7.
whereby members of the coalition enter into a partnership of shared responsibility to improve community health and well-being.\cite{Kurland_letter}

At the end of the planning period, the coalitions would be eligible to apply to fund specific implementation projects that were part of their action plans.

In July 1992, eight of twenty seven community coalitions that applied received full planning grants as recently or existing coalitions. Healthy Boston expected that the coalitions would complete the tasks of the planning period, develop an action plan, and then apply for an implementation grant. Eleven other coalitions received smaller grants to help them further develop their coalitions and prepare for a second round of funding. Seven of these coalitions and four other coalitions were later funded as recently formed in the second round.

The planning process for the coalitions funded in the first round took longer than the Healthy Boston program envisioned. At the end of the nine month planning period, many of the coalitions were not ready to apply for implementation grants. Although they completed their community assessments, they wanted more time to develop their action plans and implementation programs. Healthy Boston responded by offering an optional second date for implementation grants. Coalitions could either apply at the original date or six months later. Healthy Boston also decided to reduce the number of implementation grants awarded and developed “continuation grants” to fund further coalition building and planning activities during another year.

\cite{Kurland_letter} Kurland letter.
A few coalitions did apply for implementation grants at the first date, and others chose to wait. However, during the six month extension, the Healthy Boston program faced both political and financial pressures. A change in political administration brought a new mayor who wanted to create his own programs and a new head of Health and Hospitals who was not committed to Healthy Boston. The Healthy Boston staff faced pressure from the administration to put the money to other uses affecting their ability to award implementation grants. Healthy Boston postponed the second date for implementation grant applications.

For the next three years, the coalitions who qualified in term of showing progress on their action plan, received yearly continuations/operations grants. Coalitions were not, however, given another opportunity to apply for funding for their implementation project until two years later. Currently, the continuations/operations money is slated to run out in a few months, and both central staff and the coalitions are evaluating their next steps.

Even while changes were taking place in the central office and funding was unsure, the neighborhood coalitions continued to carry out their work. They produced a number of smaller activities and programs that were not dependent on implementation programming. These outcomes indicate the success of Healthy Boston, if success is defined as the coalitions staying together and producing collaborative outcomes in spite of the continued postponement of implementation funding. The coalitions did continue to receive continuation grants which allowed them to have a coordinator on staff if they
chose. This money also supported smaller coalition activities. Also, those coalitions that did not receive implementation grants may have stayed together based, in part, on the promise of implementation grant funding. These factors do not, however, minimize the work of the coalitions. The point is that they did stay together and continue their work.
Chapter IV: HEALTHY BOSTON IN THREE NEIGHBORHOODS

Among the neighborhoods that received first round planning grants were the Columbia Point Peninsula in Dorchester, Egleston Square, and Allston-Brighton. In this chapter, I outline what happened in these neighborhoods as they developed Healthy Boston coalitions and implemented a series of activities. These coalitions applied for Healthy Boston funding as “recently formed coalitions.” According to the Healthy Boston definition, recently formed coalitions were:

coalitions of organizations that have recently come together and have met sufficiently to have developed sense of direction and a framework for operating.\(^{42}\)

In the first year of “planning,” each coalition completed a community assessment, held a special event and produced an action plan based on the priorities that arose through the assessment process. For the next two years, Healthy Boston funded each coalition with a continuation/operations grant. One coalition applied for funding for their major implementation project at the end of year one. The other two were planning to apply six months later, but due to changes in the Healthy Boston program, they were not given an opportunity to apply until the third year of the program.

Healthy Boston required that the implementation project be collaborative, and I am concerned about the various meanings of the term in practice. During these three years, each coalition produced collaborative outcomes which can be divided into three levels.

**Level One**

Level one represents the formal programmatic outcome defined by Healthy Boston as the implementation grant. Responding to the priorities identified in their community assessments, coalitions developed implementation grants as part of a more comprehensive neighborhood Action Plan. The project was collaborative in that it grew out of a planning process involving many institutions, organizations, and individuals, and its execution required participation a number of the Healthy Boston defined neighborhood sectors. Level one outcomes are long-term programs rather than one-time events.

**Level Two**

Level two is made up of “smaller” programs usually involving fewer participants than the implementation grant, and requiring less money if any at all. These projects may be ongoing or one time events, but do not rely on the large Healthy Boston grants. Level two outcomes also include new efforts at coordination because coordination indicates a shared vision for the community. The alternative is for agencies to compete. Coalitions describe these outcomes as things that keep coalition going and things that keep people involved.
Level Three

Finally, there are the non-programmatic, but relationship outcomes which are the glue which hold together the collaboration in levels one and two. The relationship outcomes are not new programs, but elements that strengthen interpersonal relationships, what Robert Putnam refers to as social capital. Social capital is a concept that helps both to describe and value the relationships among individuals. Social capital is, in part, the additional resources that both result from and further help to develop these relationships. Keyes, building on the work of Putnam, characterizes social capital as:

1. long term relationships of trust and reciprocity
2. shared vision
3. reciprocal interest

Social capital is both an input and a by-product of the relationships. Social capital is a means to account for what comes out of the important relationships and networks that exist in communities. It is an important term to give credit to actions and outcomes that are not always visible to the naked eye nor show up on an annual report. Although Healthy Boston rewarded funds for collaborative implementation programs, implicit in its normative view of collaboration is the building of up relationships on this third, informal level.

Each of three neighborhoods I examine:

- had a different history of working together before Healthy Boston

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• chose a different structure in terms of how residents would be represented, how decisions would be made, and whether or not it would have a coordinator
• developed collaborative outcomes

To bring out these points, I outline the a neighborhood description, how the coalition came together, the coalition structure, and coalition activities in terms of three levels of collaboration described above. Although much of the focus of Healthy Boston is on the implementation project, the level two and three outcomes were critical to develop and maintain the coalitions.
IVA. Allston-Brighton

Coalition members in Allston-Brighton described Healthy Boston as something entirely new for their community. Allston-Brighton did not have a strong history of agencies and organizations working together on broad-based, sustained projects. The coalition brought together the community development corporation, area hospitals, the health center, local schools, local banks and social service providers in addition to individual neighborhood residents. The participants identified a cross cutting issue -- the influx of newly arrived immigrants -- around which the coalition focused early on. The coalition also applied for and received funding for their implementation project in the first round. Early identification of a cross-cutting issue, early implementation funding, a lack of turf issues, and a dynamic coordinator all contributed to the development of the Allston-Brighton coalition.

Neighborhood Description

Allston-Brighton covers over four square miles of land, and is home to over 70,000 people who speak more than 20 languages and dialects. The neighborhood is a unique combination of ethnic diversity, due in large part to the numbers of recently arrived immigrants and a population of long-term residents. The 1990 census of Allston-Brighton indicated changing demographics and a “neighborhood in transition.” Between 1980 and 1990, the population grew by 7.7%. The white non-Hispanic population declined by 7.1%. However, the African-American and Asian populations nearly doubled, while the Hispanic population increased by 120%. The new immigrants are
from all over the world including Haiti, Russia, Brazil, Vietnam, Cambodia, Laos, China, Ireland, and Central America.  

**How Coalition Came Together**

Service providers who knew one another through their daily work in the community started the coalition. The Director of the CDC received the application for Healthy Boston in the mail. She threw the application in the trash. “I never thought we would get the funding,” she recalled, “because generally Allston-Brighton does not appear to be as needy as other neighborhoods. We have a tougher time attracting funding.” She remembers being influenced by two people, one a board member and another person who worked with the city. “We might as well mobilize.” She first called groups she with whom she worked previously. One of the reasons she was in contact with other groups was that the CDC office is small and therefore was often looking for meeting rooms. She also knew people through participation in the Allston-Brighton Against Drugs coalition.  

The Director of the CDC knew the Director of the Jackson Mann Community Center who, in turn, knew the Director of the Joseph Smith Health Center. These individuals began to meet at the Jackson Mann Community Center. In addition to these professional connections, the coalition also benefited from personal connections. The first two co-

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45 Interview with Ginny Guild, Member, Allston-Brighton Coalition, April 10, 1996.
chairs were Diane Joyce from the Jackson Mann, and her best friend Judy Bracken who is a city employee and resident.46

It was not difficult to get an initial group together, in part because of the lack of turf issues in Allston-Brighton. The coordinator remarked, “People are willing to come to the table here. I know this is harder in other neighborhoods.”47

In this area, unlike what I’ve heard in other places, there is not so much tension. In general, people are cooperative, if they think they can help.

It’s just my experience hearing about tension in other places over territorialism. It isn’t that way around here. I don’t know why.48

Those who commented on this often ended with, “I’m not sure why.” Some, however, did offer ideas. The Healthy Boston coalition was a new coalition, and Allston-Brighton appears to be benefiting from its lack of collaborative history.

There was an understanding that this was a new coalition. It would be rude if we would fight for our own piece of the pie. It was unacceptable in an unspoken way - that would hurt things.49

It possible that there were no turf issues because institutions and organizations had not worked together before and that these issues might develop as they came together.

However, this did not occur in Allston-Brighton. Members felt that turf issues did not develop, in part, because of the early identification of a focus issue that almost everyone agreed was a priority -- the newly arrived immigrants in Allston-Brighton. The former

46 Interview with Laurie Sherman, Coordinator, Allston-Brighton Coalition, April 3 1996.
47 Sherman interview.
48 Interview with Mark Ciommo, Member, Allston-Brighton Coalition, April 11, 1996.
49 Guild interview.
Director of the CDC commented, “Part of it is we were very clear from the beginning that we had to focus on the newcomer population. How, we didn’t know.”

Coalition Structure

In the planning grant application, the coalition noted that it would have representatives from all required Healthy Boston sectors and would “try to maintain a balance of organizational versus individual membership.” Therefore, the coalition has organizational members with one vote and individual residents each with one vote. Members foresaw that the first to be involved were likely to be community leaders and stated that:

Eventually, these leaders’ constituencies may organize themselves and ask those individuals to represent the groups in the Coalition. This may then change their status from individual to organizational.

The coalition recognized that as this was a new endeavor, individuals might ultimately want to represent larger constituencies that were as of yet unorganized. The coalition wanted to have a mechanism in place to prepare for this development.

The coalition’s decision making structure is that organizations and individuals have one vote or one voice on any given motion. To share responsibility, the planning grant stated that meeting facilitation would be shared. In order for organizations and individuals to become familiar with the other organizations, the locations of the meetings would rotate.

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50 Guild interview.
52 Ibid.
Allston-Brighton members followed Healthy Boston guidelines to hire a coordinator. They originally asked one of the founding members to take the position. When she was unable, they decided to look outside of the neighborhood so that the coordinator would not have allegiance to any neighborhood based group.

Coalition Activities

In the planning grant, the coalition identified the diversity of the community as a challenge to its community’s health and used a biblical reference to the Tower of Babel to emphasize the point.

In the Old Testament, the people constructing the holy tower of Babel abandoned the project because they couldn’t communicate with one another. Even though they shared strong religious beliefs, the people of Babel could not find a common language to help them organize to meet their collective goal.53 This diversity led to the early identification of their focus issue. One member remembered:

From the very beginning, we were so clear on what we felt the priority or focus was, if we were going to have a healthy community. We had to focus on the newcomer population.54

By coalescing around this issue early on, the coalition was able to develop their implementation grant more quickly. They applied for and received implementation

53 Ibid., pg. 6.
54 Guild interview.
funding at the end of the planning period for the LINCS program (Learning to Improve Neighborhood Communication and Services). The LINCS program trains Allston-Brighton residents from different cultural and linguistic backgrounds to serve as outreach workers for their communities as they improve their English skills. In addition to advanced ESL classes, the participants are assigned to field placements at local agencies and produce community outreach projects such as a housing fair or a banking seminar “to increase communication, neighborhood participation, and access to services.”

Allston-Brighton’s story of developing the LINCS program demonstrates how one coalition developed a concrete program from a general community priority. To begin the process, the coalition sent each member (over 100 people) and service providers who were not members full copies of the report asking people to come to the next coalition meeting. To prepare for the next larger meeting, the coordinating committee and other guests met to discuss the findings of the assessment. This smaller group identified three general areas under which the “most pressing problems” fell:

1. Public safety
2. Youth Activities
3. The multiple needs of newcomers and concerns about community cohesiveness.

The group then decided to focus on the third area because, as stated in the grant proposal:

- The issue is one of the most pressing concerns for every group polled in the assessment and was the focus of the planning grant

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- some teen issues and public safety issues would be addressed in programs which look at newcomer and cohesiveness issues
- the issue is relatively unique to Allston-Brighton, as the most ethnically diverse area of Boston, and allows us to explore innovative solutions which may serve as a model for other neighborhoods and other cities.  

The coalition, in attempting to develop a “collaborative” program for Healthy Boston, chose an issue area of broad concern and where it could also address other related issues, thereby keeping a maximum number of people involved. Furthermore, the program was fundable. The full coalition later approved the findings of the smaller group.

At this point, however, the coalition still did not have a concrete program. To design the implementation project, the coalition met with over 100 immigrants who emphasized the need for more ESL classes, particularly advanced ESL classes, and outreach to ethnic communities. An Action Plan Committee then framed the implementation project as a combined advanced ESL course and outreach worker/cultural liaison program. In its ultimate incarnation, the LINCS program planned to recruit, train, and supervise up to 45 residents from different cultural and linguistic minority groups to simultaneously work on their English skills and learn how to serve as outreach workers and as “cultural liaisons” between residents and service providers.

57 Ibid., p. 37.
58 Ibid., p. 42.
The LINCS program is a level one collaborative outcome -- a Healthy Boston funded project developed by and requiring the participation of a number of agencies from different sectors. While implementing the LINCS program, the coalition developed a number of second level collaborations including:

- “YOUTH WORKS” career mentoring project
- Unsung Heroes Awards Dinner
- Black History Month Play
- Job hunting workshops.

The coalition describes these as “short-term projects and events to build community cohesion.” These events were developed by smaller committees and demonstrate the small steps the coalition took to keep people involved and produce concrete activities.

As a result of coalition meetings, agencies began to coordinate activities leading to other second level outcomes. For example, the Franciscan Children’s Hospital’s new community outreach van now takes along staff from the Allston-Brighton Women, Infants, and Children (WIC) program. These two programs came together because staff from each met for the first time at a coalition meeting. Seniors from the senior center help out with mailings for St. Elizabeth’s hospital. This again happened through individuals meeting one another at coalition meetings. These are level two outcomes because they involve new actions. People came together through the coalitions and joined forces where they could have competed.

60 “Improving Neighborhood Communication and Services,” pg. 18.
By coming together at coalition meetings, people developed interpersonal relationships, leading to third level outcomes. The former director of the Allston-Brighton Community Development Corporation (CDC) stated that:

By getting to know organizations you get to know individuals. You become professional friends. You become personal friends. It’s easier to pick up the phone to call them. Then people started to come to Allston-Brighton CDC annual meetings. People wanted to be more supportive of the staff’s of other agencies.61

Her statement indicates how relationships developed from professional to personal, and how people began to support each other personally across agencies.

Another third level outcome is described by a literacy provider who is also an Allston-Brighton resident.

I now know who to refer people to in the neighborhood. After meeting people from St. Elizabeth’s [Hospital] at a coalition meeting, I feel more comfortable calling up the hospital regarding the health concerns of my students, because I trust that they’ll be responsive.62

Thus, simply coming together around coalition meetings begins to build trust and produces the level three outcomes. Level three outcomes strengthen level one and two outcomes.

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61 Ibid.
62 Ibid., pg. 9.
A number of people cited the coalition’s role as a forum for community issues or as an umbrella group bringing together non-profits and residents. After three years, the coalition reports that out of the 350 people on its mailing list, 80-85 people attend monthly coalition meetings. They produce a quarterly newsletter, and have board meetings once a month attended by 15-17 people and full coalition meetings once a month.

In a neighborhood without strong inter-agency connections, the Healthy Boston coalition brought people together in a way in which they had never worked before, resulting in increased programming, improved communication, and new interpersonal relationships -- first, second, and third level outcomes. These outcomes were undoubtedly aided by the lack of turf issues and the coalition’s early identification of an issue around which it could coalesce.

IVB. Columbia Point Neighborhood Coalition (CPNC)

The institutions and organizations on the Columbia Point Peninsula have a history of working together. However, pre-Healthy Boston collaboration was more typical of connections between two institutions or organizations rather than the results of a broad based, multi faceted group involving the Peninsula as a whole. Healthy Boston was, therefore, a new opportunity to bring people together who had not come together in a sustained way before.
The CPNC developed program groups around three priority areas of public safety, family support, and economic development. The coalition did not apply for an implementation grant in the first round, but members continued to work in subcommittees focusing on the priority areas. The implementation grant was ultimately for a program that linked the family support program to the public school system.

**Neighborhood Description**

The Columbia Point neighborhood is the former site of the Columbia Point Public Housing Project which at one time was one of the most neglected and run-down public housing developments in the country. Today, Columbia Point is Harbor Point, a successful mixed income community owned by a unique partnership of the residents and a real estate developer. The history of the relationships of the organizations and institutions in the neighborhood must be understood in the context of this redevelopment.

The Columbia Point Neighborhood is a geographically defined 300 acre peninsula south of Boston. Of its two mile coast, all of the water’s edge around the University of Massachusetts, the JFK Library, and Harbor Point is developed as a linear park accessible to the public. Approximately 2,600 people live at Harbor Point and another 40 live at BC High School. An additional 21,197 people work or study on the Peninsula and approximately 1,000,000 visitors come to the Bayside Expo Center and the JFK Library each year.
31% of the resident of Harbor Point households fall into the low and very low income categories, but an estimated 35.5% of the low income adults are employed in low wage jobs. Harbor Point’s data indicates an overall 22% unemployment rate which breaks down into 64.5% for low income adults and 1.8% for market rate residents.63

How the Coalition Came Together

Many of the relationships today were formed or strengthened around the redevelopment of the Columbia Point Housing project into Harbor Point. This large scale physical change served as a catalyst for the different agencies on the Peninsula to, at the very least, begin to talk to one another. During the days of the Columbia Point Housing Project, there were a number of on-site agencies serving the residents, some of whom remained at the invitation of the new owners. As the redevelopment began, relationships with the institutions beyond the housing project were virtually non-existent.

Pre-Healthy Boston collaboration was typically one of a connection between two institutions or organizations. As the coalition stated in its grant proposal:

The history of coordination and collaboration among the organizations and institutions on the Columbia Point Peninsula is impressive. The richness of this history offers insight into the commitment of the institutions to create a better community. These collaborative endeavors, however, were more typical of partnerships between two institutions rather than the

63 Columbia Point Neighborhood Coalition, Community Coalition Assessment, April 1993, pg. 20.
results of a broad based, multi faceted group involving the Peninsula as a whole.64

However, the physical and social ramifications that are legacy of Columbia Point remained. Many of the buildings and institutions surrounding Harbor Point were constructed during the existence of the Columbia Point Housing Project. Because of the perceived danger of the housing project, many of these structures face inward, lack windows, and are surrounded by fences. These physical barriers do not promote an open, easily accessible community. Furthermore, many of the Columbia Point stereotypes remained. In the planning grant application, the coalition remarked:

Changing bricks and mortar has not suddenly changed the perceptions that have developed over the many years. New buildings do not erase old fears. The Peninsula community is still struggling to break down old stereotypes, both among its own institutional members and within the city as a whole. 65

The coalition building concept of Healthy Boston was timely because the physical transformation of Harbor Point was finished, and Harbor Point could look outward toward its neighbors.

Under the auspices of the Harbor Point Resident Task Force, the health center and Housing Opportunities Unlimited (HOU), Harbor Point’s resident service organization, took the lead roles. The health center initially received the information mailed out by the city and was especially interested because of the health focus. HOU served as an agency

64 Columbia Point Neighborhood Coalition, Continuation Grant Application, June, 1993, pg. 1.
coordinator at Harbor Point. HOU's Community Coordinator ran monthly agency coordinating meetings and therefore was in a logical position to try to bring a "coalition" together. Even though the HOU coordinator was a fairly recent arrival, she could tap into the already existing network of relationships. She knew the on-site agency directors through the monthly meetings. She began to make phone calls to the people, institutions and agencies with whom HOU, the Task Force, and the health center already had contacts.

**Coalition Structure**

As described in the planning grant, the coalition envisioned hiring a coordinator and sharing all leadership possibilities, such that the role of chair would rotate. The decision making process was laid out as one vote for each organization and institution. The residents of Harbor Point would be represented through the one vote of their elected body, the Harbor Point Community Task Force. The coalition did recognize that the voice of residents may be outnumbered.

As the resident Task Force may feel that with one vote, it can not adequately represent the views of all the resident. At this time, the issue has not been resolved, but the coalition has expressed an awareness of the potential problem and is willing to act on it as necessary. 66

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66 Ibid., pg. 9.
The Task Force was chosen as the Fiscal Agent, and the coalition hired two co-coordinators finding that the two people most suitable for the job could only work half time.

Coalition Activities

The community needs and resource assessment, through surveys, focus groups, statistical analysis and interviews, identified three major areas of concern which the coalition took on as its priority areas:

I. Public Safety/Community Awareness and Pride
II. Community Economic Development and Empowerment
III. Parental Involvement and Support.

At the end of the first year, the CPNC set forth a workplan and developed work groups focused on these three areas. Each work group produced a second level program outcome. The Community Empowerment and Economic Development committee initiated, on a small scale, the Job Placement and Training Referral Center to which Columbia Point Peninsula employers forward job opening information. The coalition also produced a map outlining the various jurisdictional areas for the numerous law enforcement agencies. The “Parental Support” working group developed the “My Special Parent” program in which students at the two schools, the Montessori School, the Health Center, and the two after-school program wrote essays about their parents or primary caregivers. The essays were printed in the Harbor Point newspaper distributed to all of these institutions.
The Parental Support Group also developed the Nurturing Program which, according to Don Brown, manager of Standard Uniform Services, "is really collaborative -- there are four or five groups directly involved."\textsuperscript{67} This program illustrates what Healthy Boston was striving for in terms of involvement from many sectors and a new program that could not have been accomplished by any one agency alone. Parents and children met once a week for fifteen weeks to follow a curriculum discussing such issues as communication, handling feelings, and behavior management. There were ten families involved. The families either lived at Harbor Point or had children at the Dever School Elementary School across the street from Harbor Point. The groups facilitators came from the Geiger-Gibson Health Center, the Dever School, and Harbor Point, in addition to one of the CPNC coordinators. The Dever donated space and the use of school facilities. The Health Center donated taxi vouchers for the participants who did not live at Harbor Point. Other teachers volunteered their time preparing meals. City Year volunteers from the Dever School donated extra time in addition to their regular hours to the program. Area businesses including the Boston Globe, the Bank of Boston, and several area food stores donated cash or food certificates. This was the first program of its kind involving so many organizations and institutions on the Peninsula. Healthy Boston, in asking for collaboration, pushed the coalition into implementing this kind of program. The coordinators deliberately sought a program model that required the involvement of a number of agencies and organizations. The school or the health center may have tried to

\textsuperscript{67} Interview with Don Brown, member Columbia Point Neighborhood Coalition, May 10, 1995.
implement a parenting program on its own, but it would not have served the purpose of building strong relationships across institutions and organizations.

The coalition applied for funding for the Harbor Point Family Support Initiative as its implementation proposal to Health Boston. The project was a two tiered effort combining the Nurturing Program with a Family-to-School Linkage Project to encourage parental involvement in their children's education. Describing the collaborative element of this effort, the coalition writes:

The coalition’s Parental Support and Outreach working group includes representatives of human service, education and health agencies and businesses on the Columbia Point peninsula. The selection of an appropriate program (the Nurturing Program), the design of a Nurturing Program specified to Harbor Point needs, and the dedication, time, and expertise offered by these representatives in the pilot implementation stage, constitute an extraordinary model of coordination of resources and collaboration in addressing a community need. The program staff is and will continue to be composed of personnel from the above-mentioned service providers in the community. The proposed family-to-school linkage project only services to enhance this collaboration by extending the base of family support to the public school system.68

This program was not funded although it was deemed very fundable by Healthy Boston which promised follow-up support to find other funding sources. The help has not been forthcoming and is cited by members as being a reason for a current lack of energy in the coalition. The CPNC is running a scaled down Nurturing Program due to the lack of

funds. In an effort to implement some part of the program in the absence of funding, the coalition is currently offering the classes only to parents and during the day.

While the coalition worked on their program areas, there were a number of informal level two outcomes. For example, one day, the principal of the Middle School called an HOU employee who he knew through the CPNC and asked for help in transporting two physically impaired children to the Bayside Expo Center's flower show. The HOU employee called the Health Center who had an accessible van and the children got to the flower show. This increased cooperation is a second level outcome.

The manager of the uniform company described a level three outcome. Someone was painting graffiti his trucks. Through the coalition, the manager knew a person with a good relationship with community youth. The manager mentioned the graffiti to this person who then put the out the word that the uniform company was doing good things for the community. The graffiti stopped the next day. Before the coalition, the manager did not know who to call, nor did the person who spoke to the youth know that the manager was “OK.” Through the coalition, these two men established enough of a trusting relationship that the manager knew he could call this other coalition member, and the coalition member trusted the manager enough to put the word out on the street.

Currently, energy is low in the coalition. Members attribute this to a number of things. After waiting for two years to apply for implementation funds, the coalition was not
funded. There is a sense that the members feel “they had done everything right,” but nothing happened. Now members are frustrated and mistrustful of city hall.

Both members and coordinators cited a lack of definition of roles and responsibilities of the coordinator and the “board members.” The coordinators are frustrated that the members think of ideas but do not carry them through. Members view themselves as being on a board and feel that the coordinators should do the work. In the CPNC, the coordinator remarked that, “Attendance has dropped off. If we put a program together, people would support it.” But she did not think that the energy would be there to help create a program:

The members look to us staff - you do it, you represent us. The members come to the meetings, they have good ideas, but look to us to follow it up. Maybe we do too much to make things happen.69

A coalition member highlighted the coalition’s struggle with this issue.

The coordinators are pushing the process. I think you have to have a system in place that addresses common interest, like focusing on security. But now I am afraid that if it doesn’t have someone pushing it, it will fall apart. Not that its bad to have someone pushing it.70

The coalition is still struggling to find a balance for the coordinator’s role.

Some members feel that the coalition never really reached a place where members could be honest with one another about programming concerns and sharing of resources. As an

69 Interview with Nadine Wiley, Co-coordinator Columbia Point Neighborhood Coalition, April 4, 1996.
70 Interview with David Connelly, Member Columbia Point Neighborhood Coalition, April 4, 1996.
example, referrals to certain programs were not being made, and yet those who denied such referrals were not open about their concerns.

In spite of current concerns about the energy level in the coalition, members do feel that Healthy Boston made a difference and point to the level two and three outcomes as proof.

**IVC. Egleston Square**

Healthy Boston says we want to promote collaboration. We thought they were talking about what we already do.\(^{71}\)

Egleston Square is a neighborhood with a number of active organizations and institutions and strong community leaders all of whom have a history of working together. Without Healthy Boston, these groups probably would have continued to join forces on certain issues. However, Healthy Boston was a “catalyst”\(^{72}\) to bring a larger group of people together and helped them to formalize and sustain relationships among the group members.

The players brought their history with them, and this history affected how they chose to structure their coalition exhibiting a certain sophistication in challenging some of the Healthy Boston guidelines. For example, they did not hire a coordinator because of experience with a past coalition in which participants felt that the coordinator position allowed group members to abdicate responsibility.

\(^{71}\) Interview with Laurie Holmes, Member Egleston Square Coalition, April 11, 1995.

\(^{72}\) Interview with Ediss Gandelman, Member Egleston Square Coalition March 19, 1996.
The coalition did not apply for its implementation grant at the first opportunity. During the time when they were ostensibly “waiting” to apply for the implementation grant, the coalition focused on youth programming and organized a youth council, a youth workers council, and opened up an information center.

**Neighborhood Description**

Egleston Square lies at the heart of three Boston neighborhoods: Roxbury to the northeast, Jamaica Plain to the southwest, and Dorchester to the southeast. About 15,000 people live in Egleston Square, but the number may be as high as 20,000 if the undocumented people living there are included. It is both ethnically and culturally diverse. The racial/ethnic breakdown is 45% Black, 40% Hispanic, 13% White, and 2% Asian/other. 30% of the population is under 18. 51% of the families living in Egleston earn less than $10,000 per year.\(^\text{73}\)

Egleston Square is under the jurisdiction of two police areas and two different courts. Fleet Bank has a branch in the neighborhood, and the Boston Community Loan Fund is also located in the neighborhood. It is home to several community development corporations, neighborhood health centers, active religious institutions, committees representing specific ethnic populations, and cultural institutions.

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How Coalition Came Together

Before Healthy Boston, there were a number of key events and successes that brought neighborhood residents and organizations together. In its application for the first year of planning funds, the coalition reports that “after many years of neglect, disinvestment, and lack of access to many basic services, Egleston Square was viewed by many as a ‘wasteland,’ an unsafe neighborhood to be avoided at all costs.” This image changed due to the efforts of local residents and businesses that began working together in the early 1980’s.74

The 1987 shooting of teenager Hector Morales galvanized the community and focused community efforts on youth. The organizing achievements include successful campaigns to re-open a public library and attract a YMCA and Fleet Bank to Egleston Square. Apart from these formal efforts, a coalition member commented on the informal connections among the organizations noting that before Healthy Boston they would tell each other about jobs in the community, work together to find space for meetings, and plan events together.75

In its planning grant application, Egleston Square cites six major collaborative efforts prior to Healthy Boston. It is therefore, no surprise when coalition members, thinking

74 Ibid., pg. 1.
75 Interview with Laurie Holmes, Member Egleston Square Coalition, April 11, 1996.
back on the origins of the Healthy Boston coalition said, “It was a natural thing to do.””

And another said, “We just called each other.”

When the Healthy Boston Initiative appeared, the Dimock Community Health Center and the Urban Edge Housing Development Corporation were already working on a Department of Labor grant application for an alternative high school. Dimock received the Healthy Boston information and met first with Urban Edge. There was no question about whether or not to apply. There was already “enough history” of working together in Egleston Square to get people together around the Healthy Boston concept. The key organizations early on were Egleston Square Neighborhood Association, Urban Edge, St. Mary’s, Dimock, and Ecumenical Social Action Committee. They then worked to bring in neighborhood institutions and other organizations located in Egleston, but whose work is not focused solely on Egleston such as the Boston Community Loan Fund (BCLF). The BCLF was brought in through a phone call from Mossik Hacobian, the director of Urban Edge. The Egleston Square example shows that when Healthy Boston entered an organized neighborhood, people who were already used to working with each other came together.

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76 Holmes interview.
77 Interview with Mossik Hacobian, member Egleston Square Coalition, April 9, 1996.
Coalition Structure

“Of all the coalitions, we were the one that refused to be structured.”78

“We were always a renegade coalition. This is what we do. We know how to define it. We’ll do it the Egleston Square way.”79

One of the early Healthy Boston guidelines for coalition development was that the coalitions should hire a coordinator. The coalition’s decision not to hire a coordinator is evidence of its refusal to be structured and the influence of its pre-Healthy Boston history. A few members of the coalition worked together on a previous “collaborative” effort unrelated to Healthy Boston.80 In that collaborative, these members felt that the coordinator ultimately served as a hindrance to coalition development. One member of the Egleston Square coalition remembers the decision not to hire a coordinator this way:

We talked a lot about it. Two members were strong anarchists. It was their political bent as well as their experience. They persuaded us to at least listen, and what they said made sense to me. If the Jackson Square coalition fell apart because having a coordinator meant that group members abdicated responsibility, that was enough for me.81

The coalition explained the reasons for the decision in the planning grant application.

Recognizing some of the difficulties which have befallen previous coalition who have hired a “coordinator” to staff their project, e.g. the gradual abdication of responsibility and involvement of group members,

78 Hacobian interview.
79 Holmes interview.
80 The members used the word collaborative. It does not arise out of my definitions.
81 Gandelman interview.
the Egleston Square Healthy Boston Coalition has made a deliberate
decision to keep the coordinating function within the membership group.82
Egleston’s history guided the formation of the coalition and led the members to question
Healthy Boston’s guidelines.

Egleston decided early on that individuals would participate through the already existing
resident groups and would not have individual votes. “It was an obvious decision at the
beginning. We wanted to help build the Egleston Square Neighborhood Association.”83
In its application for the first round of planning funds, Egleston Square reported that nine
of the twenty members were resident organizations, and that the coalition was planning
an outreach effort to tenants of other housing developments. The planning grant
application states:

Membership within the coalition is structured around organizations and residents
wishing to join may do so through one of the 9 resident groups.84

“The criteria for membership are few, but they demand significant commitment to agree:
(1) to do business differently together and (2) to be in the streets.”85 One coalition
member stated that they were not even sure at the time what it meant to be doing business
differently, but they realized that even if individual organizations were doing fine on their
own, they would clearly have to do it differently if they were going to work to enhance

83 Gandelman interview.
85 Egleston Square FY’95 Request for Coalition Operating Grant, June 10, 1994, pg. 4.
the work of others. Being in the streets meant that “you can’t hole yourself up in your office.” 86

Coalition Activities

The coalition did not apply for an implementation grant until its third year due to changes in the Healthy Boston central office. In the meantime, the coalition engaged in a number of other activities described in its action plan at the end of the second year of funding. These activities constitute second level collaborations -- projects not funded with the large Healthy Boston grant, but that served to make progress on the coalition priorities and keep people involved.

1. The Youth and Family Project

This project has three components: A Youth Council, a Youth Workers’ Council and a Parents’ Network. A youth/family project coordinator who facilitates these three components is housed at the Ecumenical Social Action Committee (ESAC), a coalition member. The Youth Workers Council brought together fifteen groups to better coordinate youth activities. One coalition member described the Council as particularly successful.

The youth groups came together. They figured out how to do it and not compete. There was a certain level of honesty there. 87

86 Hacobian interview.
87 Interview with DeWitt Jones, member Egleston Square Coalition, April 9, 1996
2. **The Information Center**

The coalition wanted to establish a central location for information on services and community resources. It developed the Information Resource Center which is supported by a half time resident coordinator at the Egleston Square Neighborhood Association. Among the center’s activities are the production and distribution of a monthly calendar of events and the maintenance of a job book. The purpose is to facilitate communication between the community and the coalition and within the coalition itself.

3. **Community Celebrations**

Community celebrations are important to the coalition because they play a “crucial role in uniting, strengthening and honoring diversity and common vision of a healthy community.”88 These celebrations include the Unity Games for youth and a “Dream away the Winter Blues” celebration that kicked off a poster contest for a vision of Eglston in the year 2000. Winners of the contest were recognized at the community meetings in April and their entries were published in the spring edition of the Egleston Square Coalition newsletter.

These activity areas and programs responded to coalition priorities and also served to keep members involved not only through concrete activities, but also by maintaining communication.

The Egleston Square coalition applied for its implementation grant at the end of the third year. Healthy Boston gave the coalitions only four weeks to respond to the implementation grant application and created a new category for projects that were

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88 Egleston Square Coalition Operating Grant Application, May 16, 1995, p. 17.
specifically health focused. Responding to the four week turn around time and the health focus, Egleston applied for and was funded to implement Project Breathe Easier to reduce incidences of asthma.

This project crosses many of the coalition sector including housing, economic development, education, residents, and health. It also requires the collaboration of many of the organizational and institutional members of the coalition. The organizations are listed to show the broad base of involvement by organizations and institutions of different types.

- **Provision of specialized pediatric and adult asthma services, medical care and health education:** Beth Israel Hospital, Dimock Community Health Center, Jewish Memorial Hospital
- **Implementation of teen health education efforts:** YMCA, Brookside Community Health center, Urban Edge, St. Mary’s., Y.O.U. High School, Bikes not Bombs, and Dimock’s peer leadership programs
- **Publication of asthma focused inserts in youth newsletter:** United Youth of Boston
- **Coordination of community health advocate component:** Resident and tenant association partners including Academy Homes I and II, Urban Edge Apartments

This project, although not directly evolving from the coalition’s emphasis on youth, made sense because it involved many different coalition members and therefore was collaborative by Healthy Boston standards. Asthma was also a real issue of concern for the community. The program could be developed in a short period of time and it was fundable.
An example of third level collaboration is an application submitted by Urban Edge for a Heinz Neighborhood Development Fund grant. The application is evidence of the redefinition of relationships that took place in the coalition. Urban Edge applied for the grant. The funds were, however, allocated to youth programming in three other organizations.

In essence, this grant served as our pilot program in defining what is a coalition-sponsored program (versus individual agency effort) and exemplifies one of our founding principles “to do business differently.” In effect, Urban Edge wrote this grant to support community youth activities but is not a direct beneficiary for service dollars. This is truly a step forward in collaboration and its long-term ramifications are profound. 89

This proposal is key because it shows the changing relationships that Healthy Boston sought to achieve. Not only are people coordinating, but they are, by Egleston Square’s own definition, collaborating.

Coalition members do feel that Healthy Boston has made a difference by bringing together groups in a broader sustained way than had been achieved previously, even in this neighborhood with its history of working together. “It was a tremendous catalyst.” 90

The coalition works because of the:

conviction that we can do more together than we can apart. Some of us don’t get along at all, but we still show up. 91

89 Ibid., p. 3.
90 Gandelman interview.
91 Hacobian interview.
Coalition members thus have a “shared vision.” They might not like each other, but they have a common vision for the community. Healthy Boston, then, tapped into this common vision and helped them to produce level one, two, and three outcomes.
Chapter V: CREATING THE COALITIONS

Healthy Boston asked agencies and organizations to form a coalition to break down barriers among them and develop and implement collaborative programming. To form a coalition in a neighborhood, someone has to make the first calls, and others have to show up. In developing Healthy Boston coalitions, the first calls were made largely on the basis of previous personal connections or professional connections through work. People responded to the calls for three reasons (1) personal motivations -- because a friend called, (2) professional motivations -- because they thought the connections made and knowledge gained through coalition meetings would help them to do their jobs better, and (3) institutional motivations -- they wanted to maintain or improve the reputation of their institution in the community.

VA. The First Calls

In developing the initial coalitions, the stories across the coalitions are similar even though each coalition had a different history -- Columbia Point’s intentional relationship building around the public housing redevelopment, Egleston Square’s pre-Healthy Boston collaborative successes, and Allston-Brighton’s lack of strong agency networks. Each coalition made a series of easy and hard connections. Regardless of the history in these neighborhoods, there were enough pre-existing relationships to quickly reach the stage of “recently formed coalition.” Allston-Brighton came together as a recently formed coalition based on people knowing each other without a long history of working together. Even though the Egleston Square players had a long history of working
together, they had not come together in the sustained way required by Healthy Boston. Columbia Point was somewhere in the middle with agencies and organizations working together, although largely in pairs. The history did, however, affect how each neighborhood structured its coalitions.

Healthy Boston required that the sectors of health, human services, economic development, education, and housing be represented within the coalitions. Furthermore, Healthy Boston also required that at least one-third of the membership represent organizations of residents or community members that were not service providers. Finally, at least one member of the coalition had to be a public or private institution, such as a hospital, university or corporation. Where the original coalition conveners might have just contacted people they knew, the “easy connections,” the Healthy Boston structure forced them certain cases to go beyond their personal networks to the “hard connections.” Hard connections may or may not be a result of pre-existing networks. A dense networks does imply the existence of more connections and therefore a higher likelihood that there will be fewer hard connections to make. However, there is likely to be at least one institution outside the network. Even a neighborhood like Egleston have hard connections to make.

Each coalition was initiated by personal networks. “You call people you know, people you are comfortable with.”\(^{92}\) The coalition organizers used the “easy connections” they had with other agencies -- connections made largely because community based agencies

\(^{92}\) Guild interview.
working in the same neighborhood come in contact with one another. The coalitions described a process where one person received the Request for Applications, brought together a small core group who then reached out to others in their neighborhoods.

The next level, the “hard connections” came about when coalitions tried to fulfill the Healthy Boston representation requirements. These requirements forced the coalition organizers to be more tenacious involving institutions with which they did not have previous contact. For example, the Columbia Point Neighborhood Coalition needed the membership of private business. The operations center of the Bank of Boston is located on the Columbia Point Peninsula, but connection was difficult to make. The bank was brought in eventually, because the wife of a former Harbor Point employee worked in the Bank’s downtown office and put the coalition in touch with someone at the Bank’s Columbia Point office.

Although the Bank connection was accomplished through personal networks, it was a hard connection because it was not made directly through a member of the core group. Without the impetus of Healthy Boston imposed structure, the coalition might not have made the extra effort for the hard connection. The hard connections were made even more difficult in this early phase when the goals of the coalition were still vague. It is hard to ask anyone to join a coalition without formal goals. It is especially hard to ask this of a large bureaucracy suspicious it may be asked to donate funds later on.
Furthermore, at this early phase, the coalitions did not necessarily know who to invite from a large institution. One coalition pointed to this difficulty when trying to include a large institution in its neighborhood.

Getting people to the table was also a matter of identifying the right person within the organization. CPNC [Columbia Point Neighborhood Coalition] was about improving the quality of life for all those who live work and study on the Peninsula. Therefore, it concerns the employees in the local businesses. But when approaching the Boston Globe, do you get someone from personnel or someone from community relations? A large institution’s first inclination when approached by a community organization will be to send someone from community relations.93

The coalition, realizing that its focus was on employees, encouraged participation from the head of personnel who later proved invaluable in developing the job bank.

Therefore, for the people organizing the coalitions, inviting people to the table largely involved contacting people they already knew through personal or professional networks. The Healthy Boston structure forced the individuals to work harder to include people with whom they might not have had previous relationships. The formal coalition structure made the hard connections more difficult because people with no personal or professional connections to a coalition member were asked to make a commitment to a coalition, with only a broad mission and no specific goals at this early stage. Without previous personal or professional connections, an individual is less likely to “go on faith.” However, it can be done such as in the case of the Boston Globe or the Bank of Boston in

93 Diana Markel, former co-coordinator, Columbia Point Neighborhood Coalition.
the Columbia Point Neighborhood Coalition Therefore, personal and professional connections are helpful, but not necessary to get everyone involved.

**VB. Why Are People Interested?**

Healthy Boston asked individuals and organizations to form a coalition. On the ground, there are individuals representing these agencies and organizations. Once invited, why do these individuals join the coalition? The experience of Healthy Boston participants indicate that they became involved for personal, professional, an institutional reasons.

The coordinator of the Allston-Brighton coalition, attempting to tease this out, described a combination of friendship and commitment to the Healthy Boston concept.

The Community Development Corporation, the community center, the Y, and the Health Center all have people there who are genuinely interested in stuff like this. They live in the neighborhood and they have progressive politics and people really like each other.94

A bank employee and coalition member pointed to both personal interest and institutional support behind her involvement. Personally, the Healthy Boston concept appealed to her.

I have a Master’s in Social Work. I was involved in social services at a women’s alcohol and drug treatment program. I think that agencies tend to operate in terms of fiefdoms. People have their own turf, start off with good ideas, then over time become their own entities serving themselves. People tend to be fighting problems, and don’t even realize that three other agencies are working on same problem. I saw in Healthy Boston an

94 Sherman interview.
attempt to get disparate agencies together to identify needs, come up with strategies to address those needs and try to get funding.\textsuperscript{95}

While she had a personal commitment to the concept, she also had the support of her institution. She commented on a senior manager who “had the vision of what business could do.” She personally bought into the idea and her institution supported community outreach.

On a professional level, getting to know people through the coalition helped individuals do their jobs better, The Director of a senior center remarked:

As a resident and as an agency person, you need to be connected. To find out what else is out there for your constituency, It’s the right thing to do.\textsuperscript{96} The Director of the Boston Community Loan Fund (BCLF) also commented on the importance of knowing the people in your community. “If someone needs an emergency loan, it helps to know people.”\textsuperscript{97} Professionally, some people such as community relations officers, are involved because it is their jobs to improve the standing of their institution within the neighborhood.

On an institutional level, people became involved to maintain or improve the relationship between their institution and the community. A bank was motivated by the desire to “be a good corporate citizen.”\textsuperscript{98} Don Brown, as the manager of Standard Uniform Services

\textsuperscript{95} Interview with Robin Roman Wright, Member Columbia Point Neighborhood Coalition, April 8, 1996.
\textsuperscript{96} Ciommo interview.
\textsuperscript{97} Jones interview.
\textsuperscript{98} Wright interview.
on the Columbia Point Peninsula, said he was involved because any business needs to be a good neighbor and participate in the community. If something goes wrong, then people will give Standard the benefit of the doubt. "I used to have a plant in New Jersey that blew lint around the neighborhood. Every day, people would be protesting out in front. I am trying to avoid that."99 A hospital concerned with its reputation in its community felt that the coalition provided "an opportunity to get involved with a new organization that would not already be biased against the hospital."100

Being involved in a coalition can help organizations in ways other than community relations. There are opportunities for skills and information sharing. The Boston Community Loan Fund (BCLF) director commented that if a community group were interested in starting a credit union, then the BCLF has the skills. Through the coalition, individuals from the community group could find out about the BCLF.

People joined Healthy Boston coalitions for personal reasons, for professional reasons, or for their organizations and institutions. Professional reasons sometimes became personal relationships. Inevitably, it is some combination of all three, but at least one was necessary to get people to get people to the table in the first place.

99 Brown interview.
100 Sherman interview.
More specifically, people joined because of altruism, political commitment to community politics, calculated business decisions, and pressure from friends or jobs. Coalition members described:

- **Personal reasons**
  - Friends are involved
  - Progressive politics
  - As a resident, you want to improve your community
  - Healthy Boston concept of comprehensive planning and collaboration makes sense

- **Professional Reasons**
  - Through the coalition, you will know what is going on in the community for your constituents
  - Through the coalition, you will meet more people in the neighborhood who may become know your clients
  - It is your job as a community relations specialist
  - Professional objective to make things better in the neighborhood where you are employed

- **Institutional/Organization Reasons**
  - Skills sharing -- others in the neighborhood will know what your agency/institution offers
  - Looks good to outside funders
  - Legislative mandate
  - Community relations
    - Be a good corporate citizen
    - Opportunity to improve neighborhood reputation
    - Be a good neighbor

Ultimately, it is difficult to separate the individual from the institution or the personal from the professional, and these strands do reinforce one another. Someone working at a
community based organization may be working there because of a personal commitment to community based work. Directors of communications and community relations are often in those positions because they like outreaching and working with the community. Personal commitment to the Healthy Boston concept was also necessary. As one coalition member put it, "A person couldn't go as a representative of their agency, if they didn't buy in personally." Additionally hospitals are under legislative mandate from the Massachusetts Attorney General’s office to be involved in their communities. The involvement of the hospital in one coalition was a mix of personality of the individual representing the bank, neighborhood reputation, and legislative mandate under Attorney General’s guidelines to reinvest in their neighborhoods. Clearly, the more reasons you have to be involved, the more likely it is you will stay.

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101 Ciommo interview.
Healthy Boston guidelines asked recently formed coalitions to carry out a series of activities during the nine month planning phase including developing a comprehensive plan and specific collaborative programs. Implementing a specific program raised a tension for the coalition members. How do you move forward with a particular program while keeping a group of people with diverse interests involved in the coalition? How do you maintain the coalition? As discussed in the previous chapter, individual, professional, and institutional reasons brought people to the table in the first place. In this chapter, I discuss how structural and interpersonal elements kept people involved even when a decision was made that did not directly benefit all members. Structural elements are not only the level one and two concrete programs, but also the day to day details of good organization such as skillful meeting facilitation. Interpersonal elements include the growth of professional relationships into personal ones and the development of trust and respect -- third level collaborative outcomes. In the planning and implementation phases, the structural elements helped to build the interpersonal elements.

During the first year planning phase, Healthy Boston required coalitions to develop by-laws and a mission statement, complete a community needs and resource assessment, conduct one special event, and produce an action plan outlining future activities for coalition development and project implementation. Coalition members agreed that structural activities were necessary to keep people at the table even during the planning...
phase. These early activities were critical for building one important element of relationships - trust. A member of the Egleston Square coalition pointed out that:

> The key is the trust among the players. Things like retreats, planning activities, the earlier stuff [the Healthy Boston planning activities] helps build and reinforce the trust.\(^\text{102}\)

This sentiment was also echoed by the CPNC.

> Preparing a mission statement, developing and implementing a resource and needs assessment, and a schedule of regular meetings has created a cohesive working group with a mission. This has built trust among the members.\(^\text{103}\)

For the CPNC, a cohesive working group meant a group with a shared vision. As members of both coalitions indicated, the planning phase helped to develop a group with a shared vision and trust. Coalition members described this groundwork as critical to keep the coalition together and build trust in the early phase when the activities such as developing a mission statement are often easier to agree on than making the choices necessary to move ahead with targeted programming. The targeted programming could not benefit everyone in the coalition, thus if the foundation of trust were not laid early on, members would be less likely to stay involved.

As the coalitions moved to develop concrete programs, they found that the danger in trying to appeal to as many people as possible was that the process “will get watered down.”\(^\text{104}\) Conversely, forging ahead with a specific project such as targeting youth,

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\(^{102}\) Gandelman interview.

\(^{103}\) Columbia Point Neighborhood Coalition Continuation Grant Application, June 1, 1993, pg. 4.

may have alienated an agency or individual not particularly interested in youth.

Coalitions could not remain permanently mired in planning, and their projects had to be well targeted to be successful. However, the coalitions were also trying to maintain a broad based membership. The Egleston Square coalition pointed out this very dilemma as it struggled to move ahead with focused concrete programming.

Another unwitting deterrent to maintaining the initial energy of the coalition has been our specific focus on developing a youth initiative and the delegation of that responsibility to a subcommittee. Although the end result will far outweigh any unintended consequences, the focus on youth (which was not happening in the full coalition meetings) and the narrowness of the topic (e.g. Jewish Memorial Hospital and Rehabilitation Center does not have an organizational commitment to youth) did call into question the relevance of the meetings for those not directly involved in youth programming.105

One Allston-Brighton coalition described potential coalition paralysis and one way in which her coalition tried to move on.

It's always a problem balancing. Some people probably get upset that their need is not getting addressed. There were always more issues than what we could handle, but if you try to do them all, you become paralyzed. We would have small groups at the meetings to look at issues. For example health. That group would then make a presentation to the larger group .... You deal with the highest priority, but you let people know that even if you aren't dealing with their issue right now, that it is out there106

105 Egleston Square FY’95 Request for Coalition Operating Grant. April 10, 1995, p. 6.
106 Interview with Pam Helmond, Member, Allston-Brighton Neighborhood Coalition, April 16, 1996.
Other coalitions managed this tension not only through their choice of issue, but also by carrying out other activities that led to level two and three outcomes.

The Columbia Point Neighborhood Coalition tried to manage this tension by developing priority areas so that each coalition member would have an interest in at least one area. The areas were public safety, economic development, and family and parenting issues. While these areas reflected the needs identified in the assessment, they were also a deliberate attempt to make sure “there was something in it for everyone.” For example, safety to the residents included walking to and from the train station without fear. One business institution worried about vandalism to its cars in the parking lot, and the museums were concerned about the perception of safety (or the perception of danger) which might make visitors less likely to visit them. However, they all agreed to improve public safety. Economic development meant jobs to residents and production and a consumer base to businesses. They did, however, all agree to work on creating a “viable business community on the Columbia Point Peninsula.”

In terms of choosing an issue on which to focus, most people described a trade-off between the highest priority identified by the community and what was doable in terms of funding and organizational capacity. There is no formula. One coalition laid out this dilemma when she wondered, “What decision do you make? Something fundable? Something ‘sexy’ for the funders? Something that meets the needs of the community?”

A member of another coalition stated that after listing issues in order of

107 Interview with Diane Joyce, Member, Allston-Brighton Neighborhood Coalition, April 9, 1996.
priority, the coalition would also consider the capacity of the organizations to actually be able to do something about the issue.

We might find out that can deal with number five easier than number one because of our capacity, but by doing number five, we’ll get to number one.\textsuperscript{108}

Thus, they remember that they are working toward priority number one and keep people involved with that knowledge, but they consider success on priority number five as progress toward number one.

Choices about implementation projects were made based on broad appeal of the issue, potential for multi-agency/institution involvement in carrying out a project, capacity, and fundability. The Allston-Brighton ended up building a project around newly arrived immigrants. This issue cut across the most sectors even though the project itself defined a specific target population. The CPNC produced three concrete outcomes from its working groups. It ultimately applied for an implementation grant for the family nurturing project, because that was its most successful area and involved the broadest base of support. Egleston Square applied for funding for their asthma program because the issue cut across many sectors, the coalition could develop a program that required the involvement of a number agencies and organizations, and it was fundable because Healthy Boston opened up a new category of health funding.

\textsuperscript{108} Hacobian interview.
Coalitions pointed to a number of ways to keep people involved after moving to concrete, specific projects. One key was feeding the success of the project back into the coalition as a whole. After describing a concern that the youth focus was detracting energy from the rest of the coalition, Egleston Square stated:

Having come out on the other side, however, we feel revitalized by the Youth Subcommittee’s achievements and can all share in their (and our) accomplishments.109

Additionally, level two collaborative outcomes contributed to coalition maintenance. Even though the coalitions developed primary project areas, they were also working on other projects. For example in the CPNC, the members in each priority area developed a concrete outcome such as the Job Bank and the jurisdiction map. Allston-Brighton developed a teen program while working on the LINCS project. All three coalitions worked on the already existing annual community celebrations and described these celebrations as important “community building” activities. The coalitions were consciously trying to keep individuals at the table by level one and two action, while they moved ahead with on their primary priority area.

While producing concrete level one and two programs, members described the elements of the interpersonal relationships among the individuals that kept people involved. These are level three collaborative outcomes and include elements include trust, respect, and honesty. One coalition member stated:

109 Egleston Square FY’95 Request for Coalition Operating Grant, June 6, 1995, pg. 6.
Although we disagree on some issues, there’s a lot of respect. It goes to relationship building. People see you care about your neighborhood or your agency. You can tell by the way people run their agencies or the way they treat people.¹¹⁰

The coalition meetings provided the continued contact for individuals to see that other individuals “care,” leading to a developing respect that this coalition member described as a part of relationship building. The respect then helped to keep people at the table, even though they might have disagreed about the role of the coalition in the neighborhood or about political issues.

Another coalition member commented on the importance of honesty in maintaining the coalition.

People have to be willing to be honest with each other. If Urban Edge [Community Development Corporation] were going to do something and explained their reasons, people could say hey I’m worried about parking, for example and then we could have an open honest discussion.¹¹¹

He suggested that without an atmosphere of honesty, coalition members would not raise potentially conflictual issues, thereby blocking the development of future collaborative relationships and affecting people’s willingness to participate in the coalition. With the right atmosphere, members could raise potentially sensitive issues and concerns, thus improving future working relationships.

¹¹⁰ Ciommo interview.
¹¹¹ Jones interview.
Another member also brought the issue of maintaining the coalition down to the relationships among the individuals.

People have to be willing to be self-reflective -- to create an atmosphere of how we are relating to one another - what’s good, what’s not good, and how we make it better.\(^\text{112}\)

Beyond developing concrete programs, this member was calling for a conscious effort to maintain interpersonal relationships. She recognized that as Healthy Boston asked institutions and agencies to participate in a coalition, individuals on the ground have to build relationships among themselves.

Members identified a number of structural and relationship elements necessary to keep people involved in their coalitions. The structural issues relate to level one and two collaborative outcomes and the relationship building issues relate to level three outcomes.

The issues are:

- **Structural**
  - fun meetings
  - defined goals
  - keep people busy, value them

- **Relationship Building**
  - respect
  - trust
  - people willing to be self-reflective -- to look at how we are relating to one another
  - being honest with one another

\(^{112}\) Wright interview.
• face to face contacts through meetings.

To maintain the mechanism of a coalition, members described the structural and relationship building elements that kept them involved in the coalitions and led to collaborative outcomes. Healthy Boston and other comprehensive initiatives are better at asking for collaborative outcomes than defining the outcomes or describing how to get there. While collaborative programs on the first or second level require the involvement of different agencies and institutions, people in the coalitions were worked to create trust, respect, and honesty -- third level outcomes. Therefore, while Healthy Boston specifically asked for a first level collaborative outcomes such as project and programs, it implied and the coalitions actively tried to develop third level relationship outcome.
Chapter VII: WHAT DOES COLLABORATION MEAN FOR THE PEOPLE WHO ARE TRYING TO MAKE IT HAPPEN?

Healthy Boston, similar to all comprehensive community based efforts, asked neighborhoods to break down barriers, thereby bringing fragmented sectors together. Healthy Boston operationalized their initiative by requiring neighborhoods to build coalition. The end goal was not the coalition structure itself, but the resulting collaborative programs and renewed relationships across sectors. In this chapter, I look at what the people in the neighborhoods felt that Healthy Boston asked them to accomplish. What is operational meaning of “collaboration” for the people who are trying to make it happen?

For the people on the ground, Healthy Boston’s request to develop new collaborative programs implied a leap from simply improving communication or coordinating existing activities. As one coordinator put it, “The basics are networking and communication. It’s harder to move on from that.” This coordinator went on to describe networking as “what you are doing anyway.” Her example of moving on in her coalition was a collaborative outcome between two organizations that did not have a successful working relationship before the coalition. It was through the intervention of the coalition and the coordinator that they came to apply for a grant together. The coordinator explained, “Through the coalition, they gained respect for one another. I made them respect each other.” She described this respect and the joint proposal as a collaborative outcome.

113 Sherman interview.
She went on to say that collaboration is what two organizations can do in partnership that they could not do alone, using another example of collaboration resulting from people meeting each other through the coalition. The YMCA is now running afterschool programs on site at the local schools. The Y makes some additional money and the schools to offer programming that would not have otherwise been available.\(^{114}\) Therefore, by joining forces, one organization received additional resources and another expanded its program base. Both organizations benefit in a way that could not have had they not come together.

Another coalition member also described collaboration as something beyond coordination. He began by defining coordination as the lack of duplication of services, describing agencies in his coalition who coordinated to ensure that they were not holding youth activities on the same day. Collaboration he felt, occurred in two ways and involved more agency interdependence than coordination. The first is a number of agencies working on the same program funded by a single funding source. The second is people working together on a common problem, bringing existing resources to the table. To reach this second stage, everyone has to agree that there is a problem that they want to address and:

"You’d have to build a consensus that people would see this collaborative effort as an extension of their resources or their ability to address a problem as opposed to diminishing their resources."\(^{115}\)

\(^{114}\) Sherman interview.
\(^{115}\) Connelly interview.
He saw a progression from the first to the second. It is easier to apply together for new funding, than bring your own resources to the table. Furthermore, to offer resources there must be a sense of trust. Referring back to my three levels of collaboration, progression to his second stage of collaboration requires previous level three relationship outcomes.

When coalition members thought about this next stage beyond communication and coordination, they described a blurring of resources, credit, and staff time across organizational boundaries. Members described collaboration as:

**Joint Action**
- Two or more agencies working together on one activity
- Working together on a program from a single funding source
- What two organizations can do in partnership that they couldn’t do alone
- Jointly writing a proposal
- Sharing staff

**Resources**
- Helping other agencies resources into their programs
- Working together on a common problem, bringing existing resources to the table

**Credit**
- No individual agency counting hours of services rendered as its own client hours because the program does not “belong” to any one agency
- Everyone shares in the credit of having implemented the program.

These are concrete examples of how people in the neighborhoods describe this elusive collaboration and are level one and two outcomes. The implementation projects
developed by the coalitions all involved joint agency action in developing the projects. The projects were designed so that no one agency could carry them out. All the agencies came together to write the proposal to a single funding source, and all agencies share the credit. Therefore, all achieved collaborative outcomes by their own definitions.

The coalition members did not describe what I defined as level three outcomes as collaboration. However, they talked about trust and honesty as necessary to keep people involved in the coalition. Even though Healthy Boston asked for programmatic outcomes, people in the neighborhoods felt they had to build relationships to get there. By working together to produce level one and two programmatic outcomes, they built level three relationships that then reinforced the programmatic outcomes. Collaboration, therefore, is about mutually reinforcing programs and relationships.
Chapter VIII: CONCLUSION

Given that many funders in addition to the City of Boston are increasingly asking for collaborative outcomes, I examined the experiences of the Healthy Boston participants trying to achieve collaborative outcomes to find out why people came together, why they worked together, and how they think about what it is they are being asked to do. How do the people on the ground define collaboration?

I identified three levels of collaborative outcomes that occurred in the Healthy Boston coalitions. Level one is the formal programmatic outcome defined by Healthy Boston as the implementation grant. Level two are the other “smaller” programs usually involving fewer participants than the implementation grant, and requiring less money if any at all. On Level three are the elements that strengthen interpersonal relationships, what Robert Putnam refers to as social capital.

Coalition members came together for personal, professional, and institutional reasons. In addition to these reasons, they stayed together because of structural reasons such as well-run meetings and because of level three collaborative outcomes including honesty and trust. People in the neighborhoods described collaboration, what Healthy Boston was asking them to achieve, as joint action, sharing resources, and sharing the credit for outcomes. The coalition members did not define third level outcomes as what Healthy Boston was specifically looking for, but as part of what they were working toward in order to build collaborative programming.
In the coalitions I examined, Healthy Boston built on already existing personal, professional, and institutional networks. By putting money into these neighborhoods, Healthy Boston allowed them to develop both the structural and interpersonal relationships necessary to maintain their coalition. Healthy Boston produced three kinds of collaborative outcomes, while only specifically defining one.

Healthy Boston and many of the other comprehensive initiatives described what a collaborative looks like, but not how to build relationships. Building relationships is an important part of the theory. However, outside of talking about resident empowerment, the initiatives focus on agencies, not on the individuals who have to make the collaborations happen.

Even though asking people to get over the turf issues that have built up, rightly or wrongly, over years of fighting for resources, is the right thing to do, it is a difficult task especially in these times of tightening resources. One coalition member defined collaboration as no one agency claiming client hours as their own. But agencies need to count those client hours for their funding sources. While I agree with the premise behind Healthy Boston and these other initiatives, it is important that funders realize what it is they are asking -- collaboration takes time and energy and the results take years to appear. Currently, organizations are strapped financially. I do not want to minimize Healthy Boston’s role in creating a forum for bringing people together so that the kind of exchanges that lead to coordination of activities and the building of relationships can
happen. All the coalitions cited Healthy Boston’s role as critical in creating a new, broad-based community group that increased communication and coordination. As one coalition member put it, “Communication is nothing to sneeze at.” However, the level three outcomes are critical. Although it is easy to say just get over your turf issues, it is hard to make happen and understandably harder to document. Therefore, both the coalitions and the funders are in difficult positions.

Further exploration of level three outcomes would require looking at coalitions that did not survive through three years of Healthy Boston to ask why the coalitions fell apart. It could also involve looking at coalitions who did not start off as “recently formed coalitions.” Were they able to build coalitions and relationships? Finally, it would be worth checking back in with these neighborhoods in five or ten years to see if the programs and collaborative relationships endured.

Without question, the three neighborhoods I examined felt that Healthy Boston was a success in bringing together different actors and creating new collaborative outcomes. If funders are going to continue to ask for collaborative outcomes, it will be important for them to ground their theories of collaboration in specific practice and continue to ask what it means for the people in the neighborhoods who are trying to make it happen.
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Judy Bracken, Member, Allston Brighton Neighborhood Coalition, resident Allston-Brighton

Don Brown, Member Columbia Point Neighborhood Coalition, General Manager of Standard Uniform Services

Mark Ciommo, Member Allston-Brighton Coalition, Executive Director Veronica B. Smith Multi-Service Center

David Connelly, Member Columbia Point Neighborhood Coalition, President Housing Opportunities Unlimited

John Doyle, Member, Allston Brighton Neighborhood Coalition, President and CEO Greater Boston Bank

Ediss Gandelman, Member Egleston Square Coalition, Senior Vice President Development and Public Affairs Dimock Community Health Center

Ginny Guild, Member Allston-Brighton Coalition, Former Director Allston-Brighton Community Development Corporation

Mossik Hacobian, Member Egleston Square Coalition, Director Urban Edge Housing Development Corporation

Pam Helmond, Member, Allston Brighton Neighborhood Coalition, former Director Joseph Smith Community Health Center

Laurie Holmes, Member Egleston Square Coalition, Coordinator of Economic Development, The Elizabeth Stone House

DeWitt Jones, Member Egleston Square Coalition, Executive Director, Boston Community Loan Fund

Diane Joyce, Member, Allston Brighton Neighborhood Coalition, Administrative Director Jackson Mann Community Center

Judith Kurland, former Boston Commissioner of Health and Hospitals

Jerry Mogul, Operations Manager, Healthy Boston

Laurie Sherman, Coordinator, Allston-Brighton Coalition
Nadine Wiley, co-coordinator Columbia Point Neighborhood Coalition

Robin Roman Wright, member Columbia Point Neighborhood Coalition, Bank of Boston, Program Manager McCormack School/Columbia Point Initiative