

Learning to Lead by Following: COMMUNITIES KNOW BEST

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Let us start with where Northwest Health Foundation is today and the fundamental beliefs we follow:

- Health is far more than health care. It includes physical, mental, social, and spiritual dimensions.
- Health means different things to different people, and communities improve health in all kinds of ways.
- The right people to lead health improvements are the community members most affected by them.
- Our resources are best spent in the communities that face the biggest obstacles to health.

These beliefs guide our grantmaking, advocacy, and community building. That has not always been the case, though.

Northwest Health Foundation (NWHF) has worked since 1997 to advance, support, and promote the health of the people in Oregon and southwest Washington. For most of these years, we have supported incredible work in health care and prevention. We are proud that we supported the partners and policies that led to 95 percent of Oregonians having health insurance. We are honored to have supported great nonprofit organizations that are serving families directly, making their lives better and healthier.

Yet, seven years ago, when we looked at the health of our entire community, we found many of our families were no healthier than they had been a decade ago, and they were no better off. So our foundation had to face the reality that we were doing good work, but we were treating the symptoms. We had to chart a new course.

Honestly, this new course was not one we first charted for ourselves. We were brought to this path through thoughtful, open dialogue with community-based organizations that worked directly with those most affected by poor health. They helped surface the lived experiences of families. They presented an examination of compelling data and matched that data to proven approaches that work for their community members. And they were focused on the inequities that created poor health in the first place.

With their help, our board and staff, led by our former president Thomas Aschenbrener, began a process of self-reflection. We studied the data that told us what we already knew: poor health falls disproportionately on people of color and people living with a disability. We examined our past grantmaking and published a report highlighting how we were (or were not) investing in these very communities, a report we continue to publish to this day. We joined facilitated conversations with community-based organizations. We built meaningful relationships with leaders in communities most affected by health disparities. We outlined a series of changes we could make as a foundation. We wrestled with the implications these changes would have on our grantmaking, our operations, and even our core mission.

And we changed. We made a commitment to equity, with a focus on race/ethnicity (including immigrant and refugee status), disability, and geography. We transformed our board and staff. We adopted a theory of change anchored in building strength and power within communities to advocate for themselves.

This shift is illustrated by a quick review of the titles of funded grant proposals. Ten years ago, we funded grant proposals such as “Arthritic Exercise and Aquatic Program” and “Possible Role of Cholesterol Metabolism in the Etiology of Autism and Correlates.” It is important work, but those are not projects we would fund today. In 2016, we are funding proposals with titles such as “Youth Education Advocates: Youth-Led Solutions for PK-20 Success” and “Eastern Oregon Latino Alliance for Children and Families.”

We can point to successes on this new path. The majority of both our staff and board are now people of color. In 2014, 75 percent of our grant dollars went to organizations led by communities of color, up from

25 percent in 2008. We are seeing organizations and leaders from communities of color and from disability communities emerge to tackle important policy issues on their own terms. And we are refusing to sit at decisionmaking tables, convenings, and gatherings that do not include them.

Yet we have so much more opportunity to grow—and more to discover. For instance, in 2013, only 3.4 percent of our grant dollars supported disability-led organizations. This was up from 1.2 percent, but still unacceptable. We have done intentional work on our staff and board to understand the diverse ways people and families affected by disability experience health, advocate for themselves, and lead in their communities. We are pushed by our board members and so many critical community members who have helped us honestly assess where we are falling short in doing so. We must, and we will, do better.

I join many of my counterparts in philanthropy whose foundations believe as we do. I join *them* in believing that we cannot stop this work within the boundaries of our own organizations. We have the opportunity and responsibility to change outcomes—and processes—that are much bigger than those we control alone. To me, this looks like building new leaders from diverse backgrounds and making space for their voices. This looks like decisionmaking tables, from school boards to legislatures, with plenty of seats for the families and communities most affected by poor health conditions. This looks like our nonprofit, public, and private organizations reflecting these very communities in their staffs and boards. We have got a long way to go, and I am sure we will hit many more roadblocks along the way. But the health of our families, communities, and future depends on us staying the course.

