BY THE NUMBERS:

Measuring Community Development Corporations' Capacity

by

Norman J. Glickman

and

Lisa J. Servon

RUTGERS UNIVERSITY[a]

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ABSTRACT

Community development corporations (CDCs) attempt to build capacity—that is, the ability to carry out their functions more effectively—in a variety of ways. In previous research, we defined five categories of capacity (resource, organizational, networking, programmatic, and political). In this paper, we take on the difficult task of measuring the amorphous concept of capacity building. We look specifically at the relationship between community development partnerships (CDPs), local intermediaries funded in part by the Ford Foundation to support community development, and CDCs' capacity-building efforts. Our survey of 219 CDCs allows us to provide a detailed estimation of capacity of CDCs in 20 cities. It also helps us appraise the differences partnership support makes to CDC capacity-building efforts. We found that CDCs with partnership support have greater capacity than do those without it, especially in the resource, organizational, and programmatic areas.

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1. WHAT IS CAPACITY?

Defining Capacity Comprehensively

Community development corporations (CDCs) attempt to build capacity—that is, the ability to carry out their functions more effectively—in a variety of ways. Although some community development experts measure capacity primarily in production terms (i.e., number of housing units built), capacity is really multidimensional, consisting of resource, organizational, networking, programmatic, and political elements (Glickman and Servon 1999).[1]

Resource capacity concerns the ability of firms to increase, manage, and sustain funding of their operations. CDCs spend considerable time writing proposals and courting funders in order to survive and grow. They need to manage their funds effectively. Community organizations also try to improve their internal operations and make themselves more efficient. These efforts contribute to *organizational* capacity. Increased organizational prowess may come about through training programs for staff members, development of job ladders that increase employee retention, the installation of modern software and computers for better financial management, or other mechanisms. In addition, CDCs work with others in informal and formal *networks*. For instance, they may create relationships with training organizations (such as community colleges or private industry councils) to enhance the human capital of their employees (Harrison, Weiss, and Gant 1994). Sometimes they share functions with other CDCs—for example, one may build affordable housing while another manages it. The extent to which community organizations work together effectively is another measure of capacity.

Programmatic capacity refers to the mix of activities in which CDCs engage. Community groups often initiate programs in response to the changing environment in which they operate. Most CDCs begin as builders of housing, expanding later into other areas, such as economic development or social service provision. Finally, these organizations have *political* dimensions. They must develop good relations with neighborhood residents—families that live in housing they build, members of their boards of directors, and the like—and with political and corporate powers in the city and region. Not all CDCs concern themselves with each of these elements of capacity building. However, most have become increasingly aware of the importance of these varied facets of their organizations.

Measuring Capacity Systematically

In this paper, we build on our earlier efforts to define capacity (Glickman and Servon 1999) and take on the demanding task of measuring it. We look specifically at the relationship between community development partnerships (CDPs) and CDCs' capacity-building efforts. The partnerships are local

intermediaries that attract resources from a variety of sources (including foundations, governments, and corporations) and distribute these funds to CDCs in a strategic manner. The CDPs try to select the most effective CDCs and help them by providing operating support, technical assistance, and other services.

We want to examine the effectiveness of these nonprofit organizations in terms of housing, economic development, community organizing, and the delivery of social services—whether or not they receive partnership support. This evaluation will help us measure how much internal capacity CDCs have. Our second task is to understand what differences partnership support makes to CDC capacity-building efforts. Do these local intermediaries add value in the area of capacity building to the work of the community organizations they finance?

In order to gain an understanding of the effectiveness of CDCs and the impact collaboratives have on their relative strength, it is necessary to measure the various dimensions of capacity. We approach this task with humility, since it certainly is easier to identify what kinds of capacity exist in nonprofit organizations in theory than to measure them in practice. In addition, some of the elements of capacity are more difficult and fuzzy to measure and quantify than others. For example, it is relatively easy to gauge programmatic capacity by counting the number of units the CDC produces or the additional jobs it creates. It is much more challenging, however, to measure political capacity, since both the concept of what constitutes this type of capacity and how to measure it are quite complicated.

Many CDPs are connected with community foundations or the local offices of national intermediaries, such as the Local Initiatives Support Corporation (LISC), the Enterprise Foundation, or other institutions. CDCs receiving partnership support certainly are not "average"[2]—they have a leg up on other community organizations that do not have support from local intermediaries. The Ford Foundation finances many of the CDPs, usually in concert with other foundations. Since the early 1980s, Ford has invested more than $20 million (leveraging another $30 million from other funders) in its Community Development Partnership Strategy. These funds have helped sustain more than 20 CDPs (Ford Foundation 1996). The Center for Urban Policy Research (CUPR) carried out assessments of 18 Ford funded CDPs between 1996 and 1999. This paper represents an important component of this overall effort.[3]

The measurement of capacity has long been a hot topic in the community development literature. The difficulty of measuring capacity arises in part from the mismatch between the characteristics of evaluation research and the kinds of goals that CDCs pursue. According to O'Connor (1995: 23), the evaluation field "has been preoccupied with finite, measurable program goals, discernible program components, and generalizability across locality." CDCs "have increased their emphasis on the 'intangibles' of community building such as strengthened social bonds, their conviction that the whole of the intervention is more than the sum of its parts, and their determination to become immersed in the needs and strengths unique to their communities."

Although housing constitutes the majority of CDCs' efforts, their programmatic mix isevolving. Over the past decade, these groups have become more comprehensive, adding economic development, community organizing, and social service activities to their housing efforts. In doing so, CDCs have returned to the kind of comprehensive agenda and mission of their 1960's roots. The return to a comprehensive approach to community development critically affects the way CDCs and CDPs approach the task of capacity building. According to Gittel et al. (1995: 1):

> Narrowly defined goals, such as the production of housing units, without consideration for who benefits, what the needs of the community are or whether local residents are participants limit expectations for CDCs. Admittedly, the narrower the definition of goals, the simpler the measures of performance. The broader the purpose and the greater the expectations from the CDCs, the more difficult and complex the effort to determine their achievements.

The community development literature is rife with calls to evaluate CDCs appropriately (Rich 1995). Rich (1995: 13) maintains that:

> We need to engage in rigorous empirical studies in order to better understand the nature of community-based, collaborative, revitalization initiatives . . . Do these initiatives make a difference in improving the living conditions of inner-city neighborhoods or do they simply represent the latest fad and buzzwords for repackaging old, but ineffective approaches to urban problem solving?

The literature also has produced some work on how capacity-building efforts should be assessed. OMG, in a report for National Congress for Community Economic Development (OMG 1995: 1), provided guidelines for funders to use in assessing the organizational capacity of CDCs they are considering supporting. According to this report, "it is becoming increasingly important to judge a community-based organization's competency to perform its given tasks." The National Community Development Initiative (NCDI),4 which pursued three broad goals, including "supporting CDC capacity building," attempted to document these efforts. NCDI's measures of increased CDC capacity included: housing production, growth in organizational size, programmatic diversity, and management capability. This part of our research also parallels the surveys of the National Congress for Community Economic Development (NCCED 1999), which presents overviews of the work of community development organizations. NCCED concentrated on measurable outcomes of CDC activity—primarily housing and economic development—and did not focus on capacity building to the extent that we do. In this paper, we look at the activities that dominate CDCs' work and examine whether or not emphases changed during our study period. This report is our attempt to move the field forward by tackling capacity measurement comprehensively.

In order to measure the five components of capacity, we surveyed 219 community development corporations across the country. To place the work of the Ford partnerships within the context of the overall

CDC world, we identified three categories of CDCs. First, we surveyed partnership-funded CDCs in 16 of the 18 cities where Ford funded partnerships in 1996.[5] Second, we posed a similar set of questions to CDCs in the same cities that were not supported by the CDPs. We recognized the likelihood that the partnerships chose those CDCs they considered the most effective to fund in the first place. Consequently, our results could be skewed in favor of the partnership groups. To remedy that potential problem, we surveyed community organizations in four "control" cities (Austin, TX; Denver, CO; Indianapolis, IN; and St. Louis, MO) that had no partnerships, but had reasonable histories of community development and represented different regions of the country. We map the locations of surveyed CDCs in Figure 1. Partnership-supported CDCs represented 132 of the 219 community organizations in our sample. Nonpartnership-backed CDCs (51) and control CDCs (36) rounded out our sample.[6] The survey contained 93 questions (often with follow-up or sub questions) that took the respondents—usually CDC executive directors—approximately 90 minutes to answer. All but a few of the questions were closed-ended. Local community development experts in each of the cities administered the survey. We focused on the CDPs' impacts on the community organizations, rather than the impacts of the CDCs on the neighborhoods.

2. MEASURING CAPACITY

Overview

Table 1 presents an overview of the capacity-building characteristics of CDCs in our sample.[7] The three groups of CDCs are similar in the types of areas they serve—predominantly poor, inner-city, minority neighborhoods—and the length of time that they have been in existence (about 13 years on average). They differ in their capacity characteristics, however.

Resource. The partnership-funded organizations (P-CDCs) had higher levels of core and operating support; for example, the P-CDCS had approximately 44 percent more core support than their nonpartnership equivalents. The P-CDCs had project support growing at 17.5 percent a year, compared to growth rates of 7.0 percent and 26.5 percent for the nonpartnership (NP-CDC) and control groups (C-CDC), respectively.

Organizational. P-CDCs had larger staffs, and their staffs were growing fastest among the three groups; also, benefits (as measured by the availability of pensions for the executive directors) were better for the partnership CDCs than for the others.

Networking. By most of the measures in Table 1, the P-CDCs were more likely to be involved in networks than were the other groups, although the differences between the categories were not statistically significant.

Programmatic. The partnership groups were ahead in housing production by two of the three measures presented in Table 1: total number of units constructed during the survey period and number of units under CDC management. P-CDCs' growth rates eclipsed the NP-CDCs' and were only slightly below the C-CDCs.[8]

Political. There were mixed results for political capacity. If one measure of outreach to the neighborhood is publication of a newsletter, then the partnership CDCs had the highest amount of capacity. On the other hand, P-CDCs were last in the number of public meetings held, another reasonable measure of outreach. For one element of political capacity, contact with the downtown business community, the P-CDCs led the others.

In what ways did the partnerships help the community groups they funded? Nye and Glickman (2000) interviewed CDCs and partnerships in nine cities to see if there was a good "fit" between what the CDCs needed and what the CDPs provided. The CDCs said that they most needed (1) long-term core funding; (2) access to new funding sources (beyond the partnerships); (3) help with strategic planning; (4) technical assistance; and (5) allies in publicizing the community development "agenda" with governments and business leaders. Nye and Glickman found that there was a good match between the requests of the community groups and what the intermediaries made available; in short, they worked together reasonably well—most intermediaries delivered most of what community groups wanted. However, it was useful to examine more closely the relationship between the two types of organizations—to survey a large number of CDCs to see if their needs were being met. Our survey requested that the CDCs tell us the ways in which they were most (and least) helped by the partnerships (see Table 2). We found that the CDPs did indeed help meet community group goals.

For *resource* capacity, partnership support was particularly important in leveraging project funds from other sources, contributing to long-term operating support, and contributing to project support. With respect to *organizational* capacity, nearly three-quarters of the P-CDCs surveyed claimed that partnerships improved the kind of training available to CDC staff and helped them provide training and technical assistance to staff. *Networking* capacity was increased, according to the CDCs, as partnerships facilitated the creation of joint ventures between the P-CDC and other community organizations; the partnership's role in other networking ventures appears limited, however. Regarding *programmatic* capacity, CDPs assisted CDCs in establishing financial management systems, implementing strategic planning, and developing benchmarks; CDPs contributed to programs the CDC considered successful, according to the respondents In the area of *political* capacity, partnerships were particularly helpful in brokering relationships with private-sector funders, but less helpful in improving access to elected officials. Thus, we confirmed the earlier findings of Nye and Glickman

with this more extensive examination of the relationships between CDPs and CDCs: partnerships help build the capacity of CDCs.

Before we present our findings in detail, a few words about the limitations of our data are in order. First, although our intent was to determine the contributions of the partnerships, we had no analytical way to isolate the relationships between CDP support (or lack thereof) and the indicators of capacity. Clearly, many factors affect capacity besides the presence of intermediaries. For instance, there may be differences in the characteristics of the CDCs, the community development and political climate of the city, or the region's economy. Second, some indicators are likely to be more (or less) important to CDCs' operations than others, and we have little a priori way to weight one type of capacity in relation to another. Third, the weights that CDPs and CDCs accord different types of capacity likely differ by place, mission, and maturity of the CDC. Finally, making efforts to increase capacity in a greater number of the indicators does not necessarily mean that the CDCs are better off. For instance, suppose community organization A offers more programs than organization B. If we are simply "counting programs" as our measure, we would conclude that A had more capacity than B. Nevertheless, does providing more programs mean that A is serving the community better? There is always the risk that by increasing programs the group's resources—financial and human—will be stretched too far. Organization B—which may be conserving its resources by concentrating on fewer programs—might be more effective than A. In short, more may not be better than less in all cases.

3. TYPES OF CAPACITY

3.A RESOURCE CAPACITY

Without financial resources, CDCs have little ability to have an impact on the communities they serve. According to Yin (1998: 137-8), CDCs' ability to "garner support from outside their respective neighborhoods" has been "instrumental in [their] increased capacity." How do partnership-funded community development corporations compare to others in their ability to raise funds? How do neighborhood organizations manage the funds they raise from partnerships and other sources? To answer these and related questions, we examined patterns of funding between 1992 and 1997. We also explored a variety of other issues involving resource use and management.

Funding Sources. CDCs raise money in several ways, including obtaining grants from governments and foundations for operating support and for specific projects, collecting fees and rents for property management and development fees, and generating profits from businesses. We expected the P-CDCs to attract more core operating support than the other CDCs because of their relationship with the CDPs.[9] In fact, P-CDCs exceeded the other two groups by more than 70 percent: average support for partnership organizations in 1997 was $376,000, compared to $221,000 for the nonpartnership-funded CDCs and $216,000 for the control organizations, respectively.[10] The superiority of partnership organizations was particularly clear at the upper end of the distribution: more than 31 percent of these groups raised at least $500,000 in core funding in 1997. At the same time, only 17 percent of NP-CDCs and 14 percent of the control groups were able to generate budgets of a half-million dollars or more in the same year. Significant operating support is critical to CDCs' capacity in other areas; OMG (1995: ix) found that "comprehensive operating support programs appear to have the greatest potential for positioning CDCs to improve their organizational practices, develop staff and board skills, set the stage for introducing new products such as homeownership, or otherwise enhance production."

The primary sources of core support for all types of CDCs were grants, development fees, and rents from managed properties. Interestingly, the partnership CDCs derived relatively small proportions of their operating support from the CDPs, even though one of the partnerships' main goals was to provide long-term operating funds. This mix of funding reflects both the CDCs' ability to diversify their sources of support and the reduction of funds from the Ford Foundation as Ford cut back its support of the more mature partnerships and concentrated on creating new CDPs in recent years.[11] In 1997, 68 percent of these more mature groups received less than one-quarter of their core funding from the collaboratives. In 1992, the equivalent figure was 43 percent.

We invited the CDCs to rank project funding (resources tied to specific projects) they received from different sources.[12] For partnership CDCs, the leading sources were Community Development Block Grants (48 percent named this as one of their top four sources in 1997), other federal programs (45 percent), local governments (34 percent), local foundations (26 percent), and the Low-Income Housing Tax Credit (28 percent). Further down the list of resource support were the CDPs (20 percent), corporations (17 percent), and national foundations (9 percent). Similar patterns were seen with the other two categories of CDCs. Hence, the role of the federal government in supporting CDCs' work remains critical. Corporate funding was less important. Seventeen percent of the partnership and nonpartnership organizations had corporate support, compared to 25 percent in the control group.

As shown in Table 1, the P-CDCs raised more funds for projects ($1.6 million per year on average between 1992 and 1997) than did the nonpartnership ($1.3 million) or control ($1.1 million) groups.[13] Resource

growth also differed between the organizations. From 1992 to 1997, core operating support grew by an average of 7 percent per year for partnership groups, compared to 7 percent for NP-CDCs and 3.4 percent for the control organizations. When we broke out funding by core and project components, we found that the C-CDCs had the fastest overall growth because of their ability to attract project funding (which increased at an average annual rate of 26.5 percent). These groups also had higher growth rates because their base was considerably lower than that of P-CDCs in 1992, the year we began measuring.

Asset Management. We surveyed CDCs about the management of assets, such as rental housing. In 1997, the partnership groups (74 percent of which managed housing) were midway between the NP-CDCs (66 percent) and the control groups (91 percent). Of those that managed housing, the P-CDCs were the most likely to be losing money on their projects. Thirty-one percent of the partnership groups had losses during 1997, compared to 16 percent for the control CDCs. Fewer CDCs managed commercial and industrial properties. For these activities, the partnership CDCs had relatively fewer money-losing enterprises than the other groups.[14]

Financial Conditions. We asked the CDCs how their financial condition had changed between 1995 and 1997. Seventy-four percent of the partnership CDCs reported that their finances had improved, putting them between the nonpartnership (80 percent noted improvement) and control groups (which showed an improvement rate of 61 percent).

Roles of Partnerships [15]

We posed a series of questions about how the CDPs aided the neighborhood groups' operations. Partnership-supported CDCs replied that the partnerships were helpful in their quests for funding from a variety of possible sources. By this measure, the CDPs helped raise funds for technical assistance (91 percent of CDCs asserted), operating support (according to 80 percent), and project support (said 67 percent) and helped the CDCs gain access to local funding (according to 61 percent) and private loans (said 50 percent). Nearly three-quarters believed that the CDPs increased or greatly increased their ability to gain additional funding. Only 5 percent felt that the partnerships limited their access to funders.

The partnerships' role in strengthening relations between the community groups and funders was positive—about 60 percent of the CDCs found the CDPs helpful in this area. However, when it came time to approach other funders, about half went directly to the funders and the other half worked with the partnership to "make the pitch." The CDPs were helpful to the CDCs in leveraging project funds from other sources—nearly three-quarters of the respondents said that the partnerships helped either "a great deal" or "somewhat." The help was most evident in gaining assistance from governments, private lenders, philanthropies, and

national intermediaries such as LISC. Partnership relationships were less important for leveraging funds from private developers.

3.B ORGANIZATIONAL CAPACITY

This component of capacity describes the internal operations of the CDC—how it manages itself, employs staff, develops its human capital, relates to its board of directors, and manages its finances. Experienced community development professionals often say that this element is critical to their long-term success—although it is often not well understood by the public.[16] In the survey, we inquired about training, staffing, salaries and benefits, and financial management—the major components of capacity building for organizational growth.

CDC Report Card

Training. Attempts to increase organizational capacity have been carried out primarily through technical assistance and training. For example, 82 percent of the CDPs brought in outside trainers, 76 percent paid to send CDC staff to existing external programs (that is, those run by organizations other than the CDCs themselves), 69 percent set up their own external training programs, and 48 percent used in-house training. In most cases, the partnerships employed some combination of these techniques to enhance the CDCs' human capital. In addition, CDCs engaged in internally developed training strategies to help them survive and grow.

Staff. The size and growth of staff are often the result of capacity-building efforts in the other categories. As CDCs raise additional funds and make progress with new programs, they hire new personnel. We looked at the size and growth rates of CDCs and found differences among our groups. On average, partnership CDCs had 10 full-time professionals on staff in 1997. In comparison, the nonpartnership CDCs had 7 professionals, whereas those in control cities employed 9 (Figure 2).[17] Although the partnership and control groups were of similar size when measured by number of full-time professionals, the partnership CDCs had far more nonprofessional staff (8) compared to the control cities (4). Total full-time staff for the partnerships was 15.2, compared to 12.7 for the nonpartnership and 11.3 for the control organizations.[18]

Growth rates of staff also differed among the groups. Partnership-funded CDCs registered gains in full-time employees of 10.5 percent annually between 1992 and 1997, compared to an average yearly decline of0.5 percent for nonpartnership groups. Figure 3 displays the breakdown of the growth rates by type of employee; the NP-CDCs shed an average 2.2 percent of their nonprofessional workers each year while the other two groups had increases of about 13 percent in that category. We view these comparative rates of employment

change as a mark of the relative strength of the partnership-funded organizations compared with their nonpartnership counterparts.

Staffing stability and pay are other important elements of organizational capacity. For example, we found relatively little turnover of CDC executive directors in any group. Between 1995 and 1997, 72 percent of the partnership CDCs had the services of the same executive director, and an additional 21 percent had but one change in that position. The average tenure for executive directors was nearly six years.[19] Stability in the executive director's position is important, as many CDCs are administratively thin and depend on an experienced leader.

Employees of nonprofit groups often complain about low pay and long hours. In fact, we found that the salaries of CDC employees compared unfavorably with their main market competitors—governments. Sixty-four percent of the executive directors and 60 percent of professional employees of partnership CDCs said that they made less than they would in comparable government positions.[20] Benefits packages differed across our groups. Forty-six percent of the executive directors of partnership groups had pensions, compared to 35 percent for the nonpartnership groups and 22 percent for the controls. Similarly, the partnership CDC leaders were far better off in terms of health benefits and vacation pay.[21] These advantages were enjoyed by other professional and nonprofessional staffers as well.

Other CDC Functions. The role of boards of directors varied across the groups. The boards of the control groups were the most involved in fund-raising in 1997, although the partnership boards had a longer history of involvement in this important function. Partnership boards, by a narrow margin, seemed most likely to contribute their professional expertise to the groups' activities. The P-CDCs were slightly ahead of their counterparts in the employment of computerized financial management systems.[22] The boards of partnership and nonpartnership groups had roughly equal increases in residents' representation. P-CDCs were more likely to be involved in networks than were the other organizations, although the differences between the categories were small.

Roles of Partnerships

Training. Nearly three-quarters of the partnership CDCs credited their relationship with the CDPs with improving the training available to CDC staff. The most consequential areas of training and technical assistance for the CDCs were technical training (58 percent said that this was "very important"), strategic planning (46 percent), and financial management (43 percent). *Staff.* Overall, CDPs helped improve the salary and benefit structure of the community groups they funded—39 percent said that the partnerships had assisted them in raising salaries, whereas 27 percent credited the CDPs with improving the benefits package. However, nearly two-thirds of the CDCs told us that the partnerships had little or no effect on replacing personnel who

had left; only one in seven deemed CDP help as significant in this area. Overall, only 30 percent said that the partnership was "very important" or "somewhat important" in replacing staff.

CDC Functions. CDC personnel experience constant pressure to raise funds. The CDPs helped free CDC staff from these time-consuming activities—51 percent said that time was freed up very much or a fair amount from fund-raising. Even more importantly, 73 percent stated that the partnerships had increased or greatly increased their access to additional funding.[23] When asked if the partnership had helped them gain financial stability, roughly one-third said "yes." CDCs received less help with recruitment and board functioning. Fully 40 percent of the CDCs interviewed said that the partnerships had no effect on board functioning; only 19 percent said that partnership involvement was very important to the functioning of their boards.

3.C NETWORKING CAPACITY

Networking capacity refers to CDCs' ability to interact and work with other institutions, both inside and outside the community. Networking capacity has become increasingly important to CDCs As Yin (1998: 138) illustrates: "Over the last three decades, the story of CDCs has progressed from that of the single organization making good in its community to that of participation in a complex web of partnerships." For example, CDCs sometimes contract with training institutions to help enhance their human capital or work with other CDCs to share responsibilities for housing projects or social services (Harrison, Weiss, and Gant 1994). Entering relationships with governments, private firms, or other community-based organizations may allow CDCs to extend their reach to new services and operations that are more efficient. Networking can help organizations share resources and make strategic connections to other groups. CDCs are often too small to carry out all the functions that residents and funders ask for. In such cases, forming alliances with other groups is the only way for them to respond positively. This aspect of capacity building has become particularly important given the trend toward more comprehensive approaches to community development (Aspen Roundtable 1995).

We are cautious about the number of partnerships and CDC capacity—that is, more partnerships do not necessarily translate into greater capacity. Although many experts (cited by Nye and Glickman 2000) believe that networking with other agencies and organizations is critical to CDCs' success, it is not so easy to determine which organizations a CDC should form alliances with or how many types of relationships it should maintain. The specifics of networking are very closely connected to the context in which the CDC functions. CDCs must be strategic about the specific organizations with which they partner and about the kinds of arrangements into which they enter. For example, Yin (1998: 138 [citing Rubin [1995]) states "in order to

fulfill their external relationships, CDCs may find themselves adopting practices mandated by external partners that are contrary to those of their individual stakeholders." In addition, if a CDC works with a much weaker organization, the relationship could diminish the CDC's capacity rather than build it. More partners do not always augur greater CDC success.

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We surveyed CDCs about the types of organizations they cooperate with and the sort of mutually supportive relationships that result from these collaborations. For all three categories of CDCs, community organizing, housing counseling, and housing development were the activities they were most likely to provide jointly. Between 39 percent and 65 percent of all CDCs worked cooperatively with other organizations in these areas. More than half of all CDCs surveyed worked with for-profit developers and nonprofit religious organizations.[24]

The majority of CDCs across all three categories participated in national coalitions of community-based organizations (e.g., the National Congress for Community Economic Development). Partnership CDCs reported slightly higher levels, with 66 percent participating, compared with 65 percent of nonpartnership CDCs and 57 percent of control CDCs reporting active participation in national coalitions.[25] Such participation in local coalitions of community-based organizations was much more significant across all categories, with more than 90 percent of CDCs reporting involvement.

In all three categories, at least 75 percent of CDCs reported an increase in the number of groups with which they worked during the last three years. This increase may have been the result of funders encouraging CDCs to partner with other local organizations or of CDCs creating alliances as they mature and become better able to form connections with other organizations. CDCs have broadened the scope of their work beyond housing; this trend would make these relationships more attractive.

Roles of Partnerships

We asked partnership CDCs if the intermediaries played an important role in facilitating joint ventures with a range of organizations. Partnerships had the biggest role in aiding the formation of alliances with other community-based organizations—43 percent of partnership CDCs worked actively with other community organizations. Partnerships also helped foster relations with national intermediaries (30 percent of CDCs worked with such groups), governments (22 percent), and private developers (14 percent). On the other hand, only a few CDCs claimed that partnerships had facilitated their relationships with banks.

Partnership CDCs were somewhat more likely than the other organizations to provide services jointly.[26] Nonpartnership CDCs were more likely to work with their fellow CDCs to provide staff training and

job training. Control CDCs were least likely to work collaboratively in all areas except property management. At least 25 percent of partnership CDCs work collaboratively in nearly every service category.

3.D PROGRAMMATIC CAPACITY

Programmatic capacity is the ability of the CDC to provide services that meet the needs of the target community. CDCs must build their programmatic capacity in order to respond to the growing and changing needs of the areas they serve. However, researchers and practitioners disagree as to whether or when in their development CDCs should build capacity internally, by attempting to meet new needs themselves, or externally, through linkages with other organizations. Many employ a mix of the two strategies.

In order to examine this component of capacity, we inquired about the levels of production (e.g., housing units, projects, industrial and commercial space) and the kinds of programs in which CDCs engage, including economic development, workforce development, and social services. As with the other components, we questioned partnership CDCs about which areas they thought the CDPs had contributed to their successes.

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Housing. We requested that all CDCs document the number of housing units they produced from 1992 through 1998. P-CDCs' production grew by an average of 28 percent per year between 1992 and 1998, whereas the NP-CDCs grew by 14 percent and the controls grew by 29 percent. P-CDCs demonstrated their superiority in housing in other ways.[27]

- P-CDCs were the most productive housing providers. The mean number of housing units completed between 1992 and 1998 by a P-CDC was 29, compared with NP-CDCs' 15 units and control CDCs' 21 units.[28] P-CDCs, therefore, had statistically greater production than the non-partnership groups.[29] Figure 4 illustrates production for all groups for each year 1992–1998. Not only did the partnership groups outperform the NP-CDCs in the aggregate, our data show that this was true in most of the individual cities that we surveyed. [30]

- Between 1992 and 1998, P-CDCs exhibited the most rapid growth in completed housing projects; C-CDCs' production of housing projects grew only slightly while NP-CDCs' production declined. In 1997, the average P-CDC completed 6.3 housing projects, whereas the average NP-CDC completed 3.6 and the average C-CDC completed 5.6.[31]

One way to see if partnership funding made a difference to CDC output is to compare the average annual production of P-CDCs prior to receiving partnership funding to their production levels when they received partnership funding. This approach makes sense for two reasons. First, we are comparing relatively homogeneous groups. Second, by controlling for CDC type, the problem of selection bias is reduced. Our survey provides time series information on housing units produced for the years 1992 through 1998. Moreover, 74 partnership CDCs reported that funding began between 1993 and 1997, giving us a reasonable sample.

We carried out our analysis as follows. Consider, for example, CDCs whose partnership funding began in 1995. We computed their prefunding production as the average over the years 1992 through 1995 and their postfunding production as the average over the years 1995 through 1998.[32] Using this approach, we compared the production of CDCs before and after CDP funding and found that an extra 14 units of housing were erected. This difference was statistically significant at a 0.01 level. In other words, partnership funding mattered.

Other findings included:

- P-CDCs were more efficient housing producers than NP-CDCs. We calculated the average amount of project support for each housing unit built. P-CDCs needed $54,276 to build a unit, 60 percent less than the $86,600 registered by the nonpartnership groups.
- The average number of housing units managed by a partnership CDC grew from 117 to 130 between 1992 and 1997; the number declined in the other two CDC categories.
- The ratio of rental to owner-occupied units built in 1997 was 2.5 to 1 for partnership CDCs; for nonpartnership CDCs, the ratio was 1.3 to 1; and for control CDCs, the ratio was 1.6 to 1. This ratio is important, since rental units tend to be occupied by lower-income people.

Economic Development. All CDC types had similar economic development profiles: more than 80 percent were promoting economic development projects. We also asked CDCs whether they were active in several specific areas related to economic development, such as business development and job training and placement activities.[33] Partnership CDC participation in economic development activities is only slightly higher than that of nonpartnership and control CDCs across almost all activities.

Business Development. The partnership and nonpartnership groups had similar approaches to business development.

- More than half provided technical assistance to businesses, and each gave entrepreneurial training at about the same rate (approximately 37 percent). Partnership CDCs were somewhat more likely to offer business lending (24 percent of partnership CDCs versus 17 percent of nonpartnership CDCs) and microenterprise development (25 percent versus 20 percent), but the differences were not large.

- The average partnership CDC started nine new businesses during the period 1995-1997, whereas the typical nonpartnership CDC launched six new businesses; control CDCs reported seven new firms. In every category, nearly all of these new businesses (between 83 percent and 98 percent) are still operating.

Job Training and Placement. Partnership and nonpartnership CDCs had approximately the same rate of involvement in job readiness programs, with about 42 percent of CDCs in each category participating in this activity. Nearly half of respondent partnership and nonpartnership CDCs carry out job training (48 percent and 46 percent, respectively). The responses were similar for job placement: 49 percent of partnership CDCs and 51 percent of nonpartnership CDCs engaged in this activity. Control CDCs reported the highest number of people placed in jobs through job training and placement activities. In 1997, the average C-CDC made 121 placements, whereas P-CDCs and NP-CDCs averaged 104 and 99 placements, respectively.[34]

Social Services. Partnership CDCs and control CDCs were the most likely to provide social services, with about 57 percent reporting that they do this kind of work. Forty-nine percent of nonpartnership CDCs offer social services. Interestingly, few partnership CDCs report receiving partnership funding for these social service activities. We asked those CDCs that furnish social services what kind of services they provide, and we found no significant differences between the two groups. Partnership and nonpartnership CDCs look quite similar in terms of the kinds of social services they provide and the rate at which they provide them. P-CDCs were most heavily involved in youth programs (62 percent of the CDCs provided them), education (58 percent) and cultural/arts programs (51 percent). The NP-CDCs showed similar patterns.

Community Organizing and Advocacy. Although the differences between the CDC categories were not enormous, partnership CDCs did more community organizing than the other two groups. Nearly 84 percent of partnership CDCs surveyed reported engaging in this area, whereas 78 percent of nonpartnership CDCs and 67 percent of control CDCs said they were involved in such activity.[35] Our survey data illustrate that the groups were most heavily involved in community planning (more than 80 percent of the CDCs did this task); also, more than 80 percent were engaged in organizing around specific community issues, such as housing, crime, and the like.

Benchmarks. The vast majority of CDCs in all three categories—more than 89 percent—reported that they had established benchmarks for themselves.[36] Of those CDCs that established benchmarks, most in all three categories have met them. Seventy-nine percent of partnership CDCs, 51 percent of nonpartnership CDCs, and 84 percent of control CDCs "entirely" or "mainly" met the benchmarks they set.

Perceptions of Success. CDCs in all three categories told us that they were most likely to be successful in the housing area. Fifty-nine percent of partnership CDCs, 42 percent of nonpartnership CDCs, and 46 percent of control CDCs cited housing as their most successful endeavor. This response makes sense, given that housing is the top priority of most CDCs. The community organizing and advocacy category was the second

most likely to be listed as successful by partnership and nonpartnership CDCs, with 13 percent and 16 percent, respectively, citing this activity. Social services took second place for control CDCs, with 14 percent checking this activity.

Best Practices. Asked whether there are practices or programs in which the CDC engages that staff members think could be a model for other organizations, the top three areas were housing (33 percent), organizing and advocacy (21 percent), and social services programs (11 percent). A wide variety of best practices were listed by CDCs including promotion of environmentally friendly building techniques; a lease-to-own program for risky, first-time home buyers; historic rehabilitation; neighborhood security programs; and organizing to stop illegal dumping.

Changing Priorities. The CDCs told us which activities had their highest priority during three periods: prior to 1992, 1992–1996, and 1997–1998. Overall, we found that all CDCs placed their greatest emphasis on housing in all three intervals. Of the other areas in which CDCs work (economic development, workforce development, social services, and community organizing and advocacy) CDCs reported that their social services and organizing activities declined in importance since the 1992–1996 period and economic development and workforce development took on greater importance. After housing, more CDCs in all three groups do economic development than engage in either community organizing or social services. Social services activity is the least prevalent for all three groups.

Roles of Partnership

Influence on Programs. Partnership CDCs demonstrated greater success than the other two groups in nearly all measures of housing production. Although it is impossible for us to know for sure whether the connection reflects causality, it appears that partnership support aided CDCs' housing production. After housing, partnership CDCs are most likely to engage in community organizing and advocacy activities, and partnerships are more likely to fund organizing activities than they are to fund either economic development or social services. We asked P-CDCs if the partnerships funded economic development activities. Overall, few partnership CDCs—10 percent of those that conducted any economic development activity—reported funding earmarked by the partnership for this work. More partnership CDCs reported that they received funding for community organizing than for economic development and social services. Across the range of economic development activities in which partnership CDCs participate, CDPs are most involved in funding activities related to job training and placement, less so for business assistance and development.

Influence on Measurement and Priorities. During our previous focus groups with P-CDCs, staff spoke of feeling pressure to pursue programs that had high priority with their funders. Although most P-CDCs maintained that their emphases coincided quite well with those of the partnership, priorities of some CDCs and

partnerships did not always match perfectly (Nye and Glickman 2000). Slightly more than half of the P-CDCs stated that the partnership's priorities were the same as those the CDC would have chosen itself. Twenty-five percent claimed that the partnership's priorities were "somewhat different," and 10 percent said they were "very different." Asked whether the partnership had taken on responsibilities or activities that should have been left to the CDCs, only 3 percent responded "frequently," whereas 12 percent responded "occasionally," and 76 percent said "never."

Of the partnership CDCs that reported changes in emphases between 1996 and 1998, 1992 and 1996, and prior to 1992, only 11 percent attributed the changes to the partnership. Sixty-six percent of these CDCs claimed that the partnership had little or nothing to do with the changes. Of those that responded that the changes in emphases were "strongly" or "somewhat" attributed to the partnership, 14 percent reported that the partnership had set benchmarks for them in new areas. Others said that the partnership: gave them the skills to obtain housing grants, helped them to develop their agenda, helped them to plan, increased their staff time in economic development, and/or pushed them to produce more. Still others said that the partnership shifted their funding priorities.

When asked whether the partnership had played a role in making them successful in the areas in which they reported high capacity, nearly one-third of partnership CDCs responded "very much so" and 30 percent responded "somewhat." On the other hand, 21 percent responded "not at all" to the question of whether or not the partnership had played a role.

Finally, 62 percent of partnership CDCs reported that the partnership had strongly encouraged the development of benchmarks, while 26 percent reported some encouragement, and 10 percent said the partnership was indifferent regarding the development of benchmarks.

3.E POLITICAL CAPACITY

CDCs work to represent residents and advocate on their behalf in the larger political arena in the city and region. In addition, CDCs strive to mobilize support and involve residents in determining neighborhood needs and shaping CDC policy. Political capacity manifests itself in many ways—greater community participation, more political leverage and empowerment, better-educated constituents, and effective conflict management. Building political capacity is, in many ways, the trickiest kind of capacity building that CDCs (and CDPs) negotiate. The political context in which CDCs and CDPs operate largely shapes what they can and cannot do, as Glickman and Servon (1999) argued.

We examined what CDCs do to promote support within their neighborhoods and what they considered the partnerships' roles to be in helping them increase their political reach, both within and outside their neighborhoods. We also asked the CDCs about their access to the political and corporate communities so we could determine the roles the partnerships played in brokering that access.

CDC Report Card

In order to better serve their communities, CDCs often involve neighborhood residents in governance, political action, and neighborhood events like street fairs and cleanups. For example, community-based organizations hold public meetings to discuss matters of concern to citizens. More than 70 percent of CDCs across all three categories held public meetings. Another way of involving and informing residents is through public communication, for example by publishing newsletters about the neighborhood and actions taken by the CDC. The record for the different types of groups again was similar: more than 55 percent of all CDCs surveyed publish newsletters. The three categories appear to be about equal with respect to their contacts in the corporate community.

Roles of Partnerships

Although the P-CDCs appear to have slightly greater political capacity than do the other groups, partnership CDCs tended not to grant much credit to the CDPs for improving access to elected officials or facilitating a relationship with the corporate business community. Nonetheless, the CDCs gave the partnerships high marks for strengthening relations between the CDC and private-sector funding organizations. Twenty-three percent of partnership CDCs claimed that the partnership was "very useful," and 37 percent responded that the partnership was "somewhat useful" in this regard. Only 3 percent believed that the partnership had had a negative influence.

With respect to their role in propelling the community development agenda in the public sector, the partnerships' ratings were mixed. Twenty-two percent of partnership CDCs believed that the CDP had strengthened the CDC cause "very much," and 27 percent responded that the partnership had strengthened the CDC "somewhat/adequately." On the other hand, 41 percent responded that the CDPs helped "a little" or "not at all." This finding supports what we learned in our earlier research. We found that the context of cities differs greatly with respect to the acceptability of CDCs and local governments working together closely. In some cities, such as Portland, Oregon, and Boston, such cooperation is commonplace; in others, it is nearly nonexistent.

Asked whether they contacted funders directly or through the partnership, 55 percent of partnership CDCs responded that they always contacted funders directly, whereas 42 percent claimed that they contacted funders both directly and through the partnership. Partnership CDCs tended to have more contacts in the corporate business community than did nonpartnership CDCs and control CDCs; however, the difference was not statistically significant.

Our survey showed that partnership CDCs were more likely to hold public meetings (89 percent do) than were nonpartnership CDCs (73 percent) and control CDCs (78 percent). However, partnership CDCs and nonpartnership CDCs held the least number of public meetings annually.

4 NEIGHBORHOOD IMPACTS

We inquired about measurable changes in CDCs' neighborhoods that might be at least partially attributable to their activities. We wanted this open-ended query to supplement the questions about specific elements of capacity in the questionnaire. CDCs responded with observations about changes in housing prices, crime rates, social services provision, and other neighborhood improvements. We did not attempt to verify these observations directly.

Housing Markets. Many of the respondents asserted that their organization's work in producing new or rehabilitated housing units had helped raise neighborhood housing values. They also mentioned their role in sewer and other infrastructure improvements, which contributed to housing appreciation.

Public Services and Infrastructure. The respondents identified several successful CDC efforts to improve services in poor neighborhoods. These included Head Start clinics, job training programs, health care projects, and youth development activities carried out by CDCs. Neighborhood infrastructure improvements included street resurfacing and cleaning, more sewers, better bus services, and new public schools and recreation centers that CDCs say were the result of their pressuring city officials.

Crime. Successful antidrug campaigns and community policing efforts were cited by several executive directors as contributing to a decline in crime rates and improved relations with police departments. CDCs noted efforts to reduce the number of vacant buildings, conduct prayer vigils at crack houses, help supervise juvenile offenders, and initiate "take back the streets" demonstrations that they said helped reduce neighborhood crime.

Economic Development. As we discussed in section 3.D, economic development has become a more important component of the CDC programmatic agenda. In this regard, community development organizations have helped businesses secure loans and workers obtain job training. CDCs have been active in starting and supporting retail establishments and, to a lesser degree, manufacturing plants. The CDCs said that workers were more job-ready and better trained because of their advocacy—one CDC in Cleveland claimed that it had placed 1,400 people in jobs in recent years.

Neighborhood Appearance. The way that neighborhoods look and feel is a crucial element in improving both economic development and quality of life. CDCs have been involved in neighborhood beautification, street and vacant lot cleanups, graffiti elimination, and painting buildings and improving façades. In addition, CDCs have helped with the landscaping of problem properties, been involved in community gardens, and carried out plantings on vacant lots.

Resident Involvement in Community Activities. Lastly, the CDC executive directors said that their organizations had worked to increase the involvement of residents in community life. Such involvement has come about through the implementation of community meetings, public forums, newsletters, and related measures.

The responses reported in this section were not tied to hard numbers, as they were elsewhere in this paper. Rather, they reflect the views of the executive directors; we had no way to cross-check their comments. However, they provide further insight into the workings of the groups.

5. CONCLUSIONS

This paper represents our best efforts to measure the components of community development capacity. We recognize, as we stated at the outset, that some important dimensions of these components are very difficult to measure through a survey. Having put forth that caveat, the question remains: does partnership support make a difference in CDCs' quest to build capacity? We believe the answer is yes. Our research demonstrates that CDPs make important contributions across the five components of capacity. P-CDCs have greater resources, larger and better-paid staffs, and greater housing outputs. P-CDCs also maintain that partnership support helps them significantly in areas that range across the five components of capacity. Specifically, CDPs have helped P-CDCs to raise more long-term operating support, offer better training to their staffs, develop benchmarks, and strengthen their relationships with private-sector funders.

Although some components of capacity proved more difficult to measure than others, we believe that we achieved our goal of pushing the field of community development evaluation forward with this paper. Our framework of five components of capacity—resource, organizational, networking, programmatic, and political—enabled us to approach the issue of CDC capacity systematically and to show real differences between the three categories of CDCs in some critical areas.

Our findings also lead us to make a few policy recommendations and to set forth some directions for future research. We believe that support for the partnership concept should be continued and provided by both foundations and governments. We recommend a support network involving partnerships between

philanthropic, government, and private for-profit entities since CDCs that have partnership support have greater capacity. Although we did not measure neighborhood impacts, we can argue with a good degree of certainty that their greater strength makes P-CDCs better able to produce positive results in poor neighborhoods. One thing we discovered through our survey was that many CDCs rely on the federal government—particularly the Community Development Block Grant (CDBG) program—for support. The CDBG program should be continued in order to support this important work. While CDPs help CDCs build capacity, local-level partnerships know the communities and the organizations operating in these communities. They are able to determine which CDCs are most capable of building capacity in these communities, and they can tailor funding and accountability requirements to meet the needs of the local organizations.

Several important areas remain in which we need to expand our knowledge. These areas guide our recommendations about directions for future research. First, researchers should pursue better methods of measuring the more elusive aspects of capacity, particularly political and networking. Second, more research is needed about whether and how CDPs should target their support toward specific activities. In which specific areas does partnership support elicit the most bang for the buck? Third, researchers should work toward understanding the relationship between CDC capacity and neighborhood impacts—how does increased CDC capacity translate into better communities? We did not answer that important question since we focused on the capacity of organizations. We hope—and believe for the most part—that this capacity translates into outcomes that lead to positive neighborhood change. However, our work stops short of examining the changes that CDCs effect. The next step would be to ask the following questions. First, what is the relationship between community development programs and the conditions of poor neighborhoods? Little work has been done to measure the impacts of these organizations on neighborhoods. Second, how, if at all, do neighborhoods where partnership-funded CDCs operate differ from comparable neighborhoods where partnership-funded CDCs are not operating? Answering these questions would greatly aid in the formation of policy and help guide practice.

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TABLES AND FIGURES

Table 1

HOW THEY STACK UP: A PROFILE OF COMMUNITY DEVELOPMENT CORPORATIONS' CAPACITY[t]

	Partnership	Nonpartnership	Control
Resource Capacity			
Core Operating Support ($000)	318	221	206
Project Support ($000)	1,574	1,299	1,155
Average Annual Growth of Project Support (%)	17.5	7.0	26.5
Organizational Capacity			
Full-Time Professionals (Number)	13.0	8.7	8.9
Average Annual Growth of Staff, 1992-1997 (%)	12.5	3.0	7.9
Pension Coverage for Executive Director (%)	46	37	25
Networking Capacity			
Supports Staff Training with other CDCs (%)	32	33	25
Supports Community Organizing with other CDCs (%)	64	63	53
Works with For-Profit Developers (%)	65	58	75
Programmatic Capacity			
Total Housing Units Completed, 1992-1998 (Number)	203	107	147
Average Annual Growth of Housing Units Completed, 1992-1997 (%)	28.0	14.0	29.0
Housing Units Managed 1997 (Number)	110	72	70
Political Capacity			
Publishes a Newsletter (%)	66	57	58
Has Contacts with Business Community (%)	44	37	36
Public Meetings per Year (Number)	8	17	23

[t] All figures are 1992-1997 annual averages, with the exception of Total Housing Units, which are for 1992-1998.

Table 2

DIFFERENCES PARTNERSHIP SUPPORT MAKES

TYPE OF CAPACITY	Partnership CDC Responded "Very Important or Somewhat Important"[a]
RESOURCE CAPACITY	
Freed time formerly spent on fund-raising	53%
Assisted in leveraging project funds from other sources	73%
Increased access to funding due to working with partnership	27%
Contributed to long-term operating support	81%
Contributed to project support	67%
ORGANIZATIONAL CAPACITY	
Caused staff benefits to increase	27%
Improved the kind of training available to CDC staff	74%
Improved the process for replacing personnel	30%
Provided training and other forms of technical assistance	74%
Assisted recruitment of staff	30%
NETWORKING CAPACITY	
CDCs that said partnerships facilitated joint ventures with:	**Percent**
Other community-based organizations	**43%**
Private developers	**14%**
Governmental bodies	**22%**
National intermediaries	**30%**
Other	**5%**
PROGRAMMATIC CAPACITY	
Established financial management systems	58%
Developed a strategic planning process	64%
Encouraged development of benchmarks	88%
Contributed to programs that CDC regards as successful	61%
POLITICAL CAPACITY	
Improved access to elected officials	26%
Facilitated relationship with the corporate business community	41%
Strengthened relations with private-sector funder	60%

[a] We use "very important or somewhat important" here in order to streamline Table 2. Actual wording for response choices varied somewhat among the questions. For example, some answers were "very useful or somewhat useful" or "strong encouragement or some encouragement."

Figure 1: Location of Surveyed CDCs

Figure 2

Number of Full-time Staff (1997)

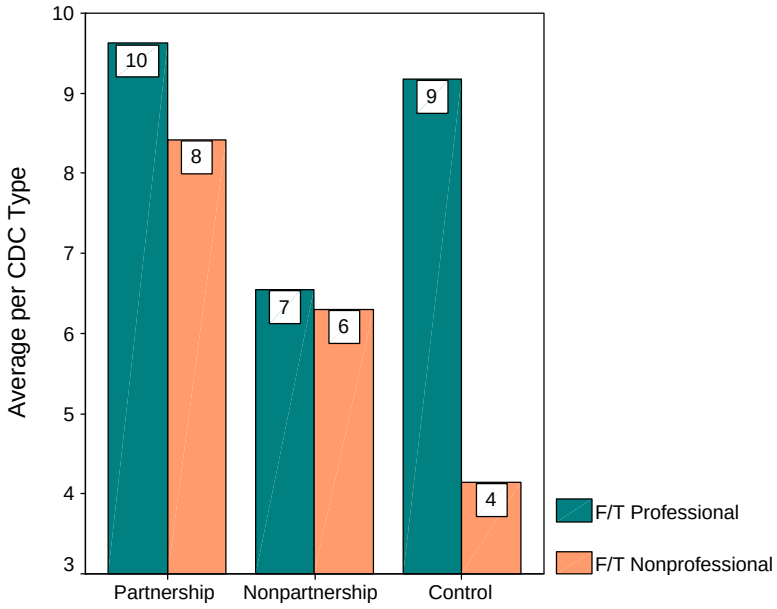


Figure 3

Average Annual Growth of Full-time Staff (1992-1997)

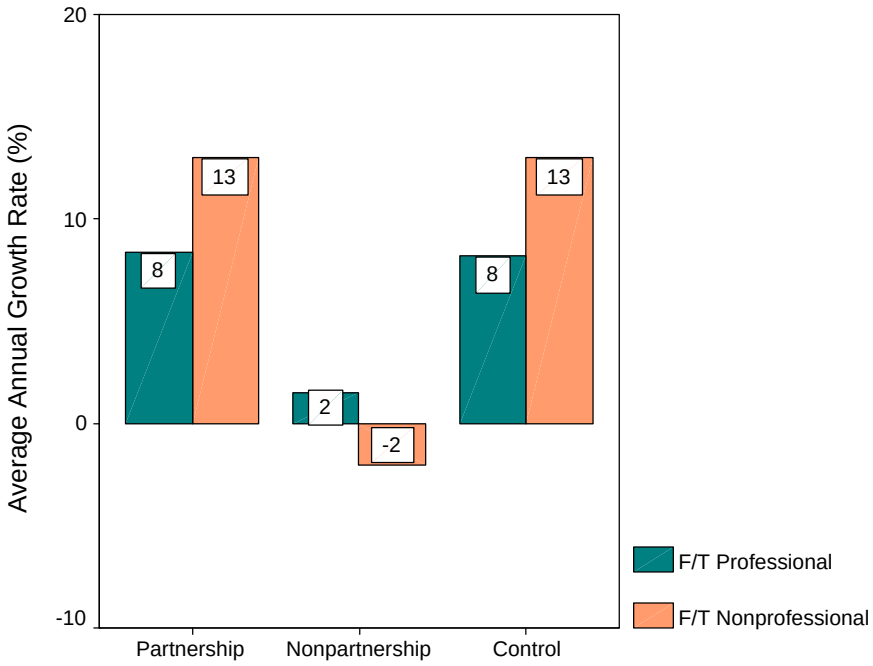
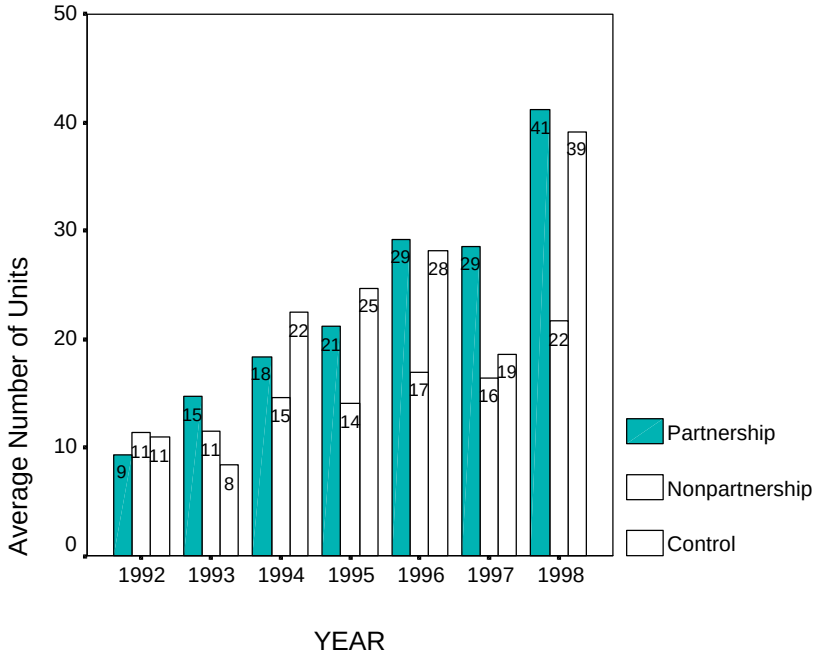


Figure 4

Housing Units Completed (Annual Average)



NOTES:

[1] Walker and Weinheimer (1998) view the elements of capacity as: 1) the ability to plan effectively; 2) the ability to secure resources; 3) strong management and governance; program delivery capacity; and the ability to network with other clients. These categories are similar to ours, save their first group.

[2]Liou and Stroh (1999) discuss national intermediaries, such as LISC, Enterprise, and the National Reinvestment Corporation, that fund community development organizations. Each national intermediary comes from different roots (Ford initiated LISC, Enterprise was founded by the builder James Rouse, and NRC grew out of a federal government initiative) and each has different goals and operating principals. We observe local intermediaries in this research, although some of these are linked to the local affiliates of LISC and Enterprise. Many others have written on intermediaries and partnerships, among them Berger and Kasper (1993), Carroll (1992), Cohen (1993), Fulton (1989), National Congress for Community Economic Development (1991), and Sviridoff (1994).

[3] CUPR's work has consisted of a conceptual essay on the nature of capacity (Glickman and Servon 1999), a set of focus groups and interviews to test the framework (Nye and Glickman 2000), and case studies of capacity building in five cities (Cleveland; El Paso; Minneapolis; Philadelphia; and Portland, Oregon). See Lowe 1998, Mueller 1998, Goetz 1998, Shatkin 1998, and Hoereth 1998.

[4] NCDI was established in 1991 as a consortium of eight national corporate and philanthropic funders charged with bringing together and employing "new philanthropic resources to help accelerate the growth of CDCs nationally and to boost their efforts to revitalize troubled neighborhoods in low-income communities" (NCDI Phase I, July 1995). NCDI continues to be supported by the original funders and was linked to the Human Capital Development Initiative in 1997. HCDI, as the name implies, is aimed at increasing the quantity and quality of practitioners in the community development field

[5] We did not evaluate a statewide partnership in North Carolina or the partnership in Puerto Rico that encompasses that island. We focused on the work of citywide intermediaries where Ford made investments.

[6] We set a goal of interviewing 13 CDCs in each city. In partnership cities, we attempted to interview nine partnership and four nonpartnership CDCs; in the control cities, our goal was also 13 groups. The universe of P-CDCs came from the partnerships; additional organizations were identified from lists of CDCs kept by city agencies (e.g., the city planning or housing departments). In some cases, we were successful in interviewing 13 CDCs; in other cities, there were not enough CDCs in operation or we did not get the cooperation of a sufficient number of executive directors to reach our goal. Since we were not successful in interviewing all the CDCs in the cities, this was not a census. Nor was this a formal random sample of organizations—the groups we spoke with represent our best efforts to reach as many CDCs as we could.

[7] A detailed statistical portrait of the CDPs is available from the CUPR website at http://www.policy.rutgers.edu/cupr/. In addition, as with all samples—even one as rich as the one we discuss here—there are anomalies and outliers that affect the statistics. In some of the variables, we found that there were outliers that made for odd-looking statistics of central tendency. We note some of these outliers later in the paper and adjust for their effects when appropriate. See, for example, footnote 34.

[8] The C-CDCs began the period at a much lower absolute level than the P-CDCs—this accentuated the control groups' growth rates.

[9] In the survey, core support was defined as the sum of grants, development fees, contract fees for services, rental revenues, revenues from sales of buildings, and business income. In other words, all funds that came to the CDCs not earmarked for particular projects and thus available for general support of the CDCs' operations. Although rents and management fees for rental properties flow from particular projects, the use of these funds is relatively unrestricted and is fungible with other resources of the organization.

[10] The amount of core support raised by P-CDCs was significantly greater than the NP-CDC and C-CDCs at a 5 percent confidence level.

[11] The Ford Foundation began to fund new partnerships in the Southeast during the late 1990s, including some in rural areas that we did not study. Many of the established CDPs—those that received Ford funding in the 1980s and early 1990s—did not get any more money in recent years. Consequently, these more mature CDPs had to raise a substantial amount of their operating support (in some cases, all of their operating funds) from non-Ford sources.

[12] The list of sources they picked consisted of CDBG, the Low-Income Housing Tax Credit, Section 8, other federal government funds (such as HOME, Enterprise Zones, and the like), state and local governments, national foundations, local foundations, national intermediaries (e.g., LISC, Enterprise), community development partnerships, United Way, corporate giving, bank loans, and others. We asked the CDCs to select the four most important sources of funds from this list, and we report these figures here.

[13] The advantage of the P-CDCs, however, was not statistically significant.

[14] The number of CDCs operating commercial and industrial properties was so small that strong statements about success or failure are hard to make with confidence. For example, while 97 of the partnership CDCs managed housing, only 44 had commercial ventures and only five were involved in industrial production. The other groups showed similar distributions.

[15] Throughout the survey, we asked a series of questions to gauge the importance of the partnerships in helping to build capacity in the CDCs. Although the questions differed slightly in some cases, we asked each organization to choose between five answers to the question, "Has the partnership made an important contribution to this aspect of capacity?" The choices were: 1) very important, 2) somewhat important, 3) marginal/very little, 4) not at all, and 5) don't know. In sections 3A through 3E, we refer to the first two categories as being "helpful" or "useful" to the CDCs and the third and fourth as being "unhelpful."

[16] Three major funders of community development (the Annie E. Casey, Ford, and Rockefeller Foundations) have banded together (along with the funders of the National Community Development Initiative) to invest in the Human Capital Development Initiative. This effort is aimed at increasing the stock of human capital through the recruitment and training of people in CDCs. This is an important effort in the area of organizational capacity building. Most of the HCDI sites are also Ford-funded partnerships.

[17] P-CDCs' employment levels were greater than the NP-CDCs' at a statistically significant level of 5 percent.

[18] Our statistical tests of differences between the means for full-time and total staff showed that the P-CDCs' had more than the NP-CDCs at a 15 percent level of confidence in both categories. There was not a significant difference between the P-CDCs and the C-CDCs.

[19] Note, however, that the other types of CDCs had similar turnover rates, so the partnership-funded CDCs had no distinct advantage in this regard.

[20] This also was true for the other types of organizations. For instance, 79 percent of the executive directors of nonpartnership CDCs made less than those in government; for the control CDCs, the applicable number was 74 percent. There were mixed results for benefit packages. They were better for the partnership executive directors (who were more likely to receive pensions, health benefits, and paid vacations than those in the other groups), but worse for other employees.

[21] For example, partnership CDC executive directors had substantially better dental, disability, life insurance, and sick-leave packages compared to the control group directors.

[22] There was no statistical difference between P-CDCs and NP-CDCs with respect to use of computerized systems. The partnership groups were more likely to have these systems than control groups at a .10 significance level.

[23] By contrast, only 5 percent complained that the CDPs limited their access to funding. Five percent said that the partnerships had reduced their access to other funders.

[24] CDCs were much more likely to operate subsidiaries (either on a for-profit or nonprofit basis) than to be subsidiaries of other organizations. Forty-seven percent of partnership CDCs had subsidiaries, whereas 34 percent of nonpartnership CDCs and 44 percent of control CDCs encompass them.

[25] These differences were not statistically significant.

[26] We asked about the following services: staff training, community organizing, housing counseling, housing development, commercial real estate development, property management, job training, job placement, and business assistance.

[27] The 1998 housing data are included because they measure the number of units under construction. This provides the best proxy for estimated output for that year; therefore, its inclusion is important for computing annual average housing production. We understand, of course, that not all units in the pipeline are completed.

[28] A substantial portion (81 percent) of partnership CDCs did not begin to receive funding until 1992 or later. In order to reduce biased comparisons, annual average output for these CDCs do not include production levels during the years that cannot be (directly or indirectly) associated with partnership funding. Thus, we adjusted the sample data for each partnership CDC accordingly: if funding begins in year t then average annual output is based on year t+1 onward since, a priori, it is reasonable to assume a lag period of approximately one to one-and-a-half years for housing production.

[29] The results of statistical tests showed that the partnership CDCs' mean production (29) was statistically greater than that of the nonpartnership CDCs (15) at a 95 percent confidence interval. Similar tests showed that there was no significant difference between the P-CDCs and the control organizations.

[30] P-CDCs had more production than NP-CDCs in all cities but Atlanta. The differences were significant at a 10 percent level in New Orleans and Philadelphia and at a 20 percent level in Cleveland, El Paso, Pittsburgh, San Diego, and Washington, D.C.

[31] A project consists of a set of housing units built at the same time by the same CDC developer.

[32] More generally, if t=year partnership funding began and X(i) =total units for year i, then the prefunding annual average is based on X(92),X(93), …X(t-1), X(t), while the postfunding annual average is based on X(t), X(t+1), …X(97), X(98).

[33] The most frequently provided services were property development, technical assistance to businesses, and job placement. Nearly one-third of partnership and nonpartnership CDCs engaged in what we labeled "other" economic development activities. These included façade improvements, individual development accounts, referrals for business, and Main Street programs.

[34] The raw survey numbers showed that nonpartnership CDCs placed more people in jobs than partnership CDCs. Further inspection of the data, however, revealed that the relatively large average (352) for NP-CDCs can be attributed to two CDCs—Peoples Involvement Corp. (Washington, D.C.) and Watts Labor Community Action Committee (Los Angeles). These two organizations reported 4,000 and 2,520 placements, respectively. These numbers are found to be very extreme (i.e., outliers) relative to the groups' general distributions. Hence, a formal comparison of means would yield misleading inferences, as the two groups are too heterogeneous with respect to their variability (the standard deviation was 149 for P-CDCs and 908 for NP-CDCs). Omitting the outliers significantly reduces the variability, resulting in an adjusted mean of 99 job placements by NP-CDCs. Given that the mean for P-CDCs is 104, there was no significant difference between the two groups. Looking at individual cities, P-CDCs had more placements than NP-CDCs in Atlanta, Camden, Cleveland, Miami, Newark, Philadelphia, and San Diego. The NP-CDCs had more placements in the other cities.

[35] The differences between the P-CDCs and the other groups were not statistically significant, however.

[36] The Washington Community Development Collaborative (1997) developed a useful set of guidelines for measuring benchmarks. The North Carolina Community Development Initiative (2000), expanded our capacity categories into nine "working principle" to help it make grants to community organizations.