Micro grants as a stimulus for community action in residential health programmes: a case study

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SUMMARY
This paper aimed to explore the contribution of a micro grant financing scheme to community action in terms of residential health-promoting initiatives, interorganizational collaboration and public participation. The scheme was two-fold, consisting of (i) micro grants of 500–3500 Euros, which were easily obtainable by local organizations and (ii) neighbourhood health panels of community and health workers, functioning as a distributing mechanism. Data were collected using three methods: (i) observations of the neighbourhood-based health panels, (ii) in-depth interviews with policy-makers and professionals and (iii) analyses of documents and reports. This study demonstrated the three-fold role of micro grants as a vehicle to enable community action at an organizational level in terms of increased network activities between the local organizations, to set an agenda for the ‘health topic’ in non-traditional health agencies and to enable a number of health-promoting initiatives. Although these initiatives were attended by small groups of residents normally considered hard to reach, the actual public participation was limited. In their role as a distributing mechanism, the health panels were vital with regard to the achieved impact on the community action. However, certain limitations were also seen, which were related to the governance of the panels. This case study provides evidence to suggest that micro grants have the potential to stimulate community action at an organizational and a residential level, but with the prerequisite that grants be accompanied by increased investments in infrastructure.

Key words: micro grants; community action; health programmes

INTRODUCTION
Over the past two decades, community health initiatives have been a popular approach to improve the health of communities (Bracht, 1999; Boutilier et al., 2000; Merzel and D’Afflitti, 2003). A central goal of this approach is to stimulate community action, whereby citizens and organizations (i) become aware of an existing condition or problem, (ii) identify that condition as a priority, (iii) institute steps to change the condition and (iv) establish structures to implement and maintain programme solutions (Bracht et al., 1999). Two core strategies to realize community action are interorganizational collaboration and public participation. In practice, the record of success for these strategies is mixed. It appears difficult to improve interorganizational collaboration, which in public health often occurs in coalitions. Current studies show marginal results (Berkowitz, 2001), and the literature provides little consensus on which coalition-building factors promote effective collaboration and community change (Foster-Fishman et al., 2001; Zakocs and Edwards, 2006). Obtaining and maintaining the desired level of public participation is also a problem. Evaluations have...
shown that the levels of participation are often inadequate for promoting serious community action (Merzel and D’Afflitti, 2003).

In health promotion, micro grant schemes are an innovative way to stimulate community action that includes interorganizational collaboration and public participation (Foster-Fishman et al., 2006; Hartwig et al., 2006). Micro grants are small budgets (up to 3500 Euros) easily obtainable by local organizations (Johnson et al., 2007) and resident groups (Foster-Fishman et al., 2006) applied to instigate local health initiatives. The premise of these grants is that recipients are able to obtain ‘quick wins’ in their neighbourhood, which in turn demonstrate that their efforts make change possible (Foster-Fishman et al., 2006). Thus, community action in which local organizations and residents are stimulated to act on health is encouraged. The few evaluation studies of micro grant schemes show that they can prompt many health-related activities (Bobbitt-Cooke, 2005), enhance the involvement of non-traditional health agencies (Hartwig et al., 2006) and encourage the short-term involvement of residents (Foster-Fishman et al., 2006). These results indicate that micro grants are a promising incentive to stimulate community action. However, little is known of the distribution mechanisms and their overall effect.

The establishment of a micro grant scheme in The Hague provided an opportunity to observe its impact and the manner of distribution. In this paper, we aimed first at describing the impact in terms of initiatives, interorganizational collaboration and public participation, and second at exploring neighbourhood health panels as distributing mechanisms.

CASE DESCRIPTION AND BACKGROUND

In 2004, the micro grant scheme was initiated within the context of an urban health programme aimed at reducing health inequalities in six deprived neighbourhoods in The Hague. The municipality initiated the scheme to facilitate a quick response to small-scale initiatives of neighbourhood health and community workers. Community action was expected with regard to (i) commitment of the workers in the health field, (ii) interorganizational collaboration and (iii) activities that would respond to the actual needs of residents preferably by their active participation.

A budget of 20 000 Euros per neighbourhood was made available for small-scale activities (500–3500 Euros), and the money could be obtained by a simple municipal procedure.

The policy-makers felt that the distribution of funds was the prerogative of the health and community workers. Therefore, from 2005 onwards, six neighbourhood-based health panels were organized, in which health and community workers were invited to distribute the grants.

The panels met twice a year and were chaired by two municipal health service (MHS) workers. The municipality formulated five criteria: (i) the initiative had to concern physical activity, health nutrition, pedagogic support or access to health care; (ii) it had to contribute to empowerment of the residents; (iii) it had to be innovative; (iv) applicants had to contribute ideas about sustaining the initiative; and (v) collaboration between the health and community workers was required.

METHODS

To determine the scheme’s impact, we studied the community action that was achieved. We specifically assessed: (i) which micro grant initiatives were granted; (ii) how the grants were distributed and (iii) to what extent the community was mobilized. The micro grants and the neighbourhood health panels were evaluated over a 2-year period, using three methods: observation, in-depth interviews and document analyses.

Collecting and analysing observations

In 2005, each of the two panel meetings was observed by two researchers (M.S./T.P./V. Nierkens/K.S.) and in 2006 by one researcher (M.S.). To record field notes, a semi-structured observation guide was used consisting of seven main topics: strategic vision, leadership, financial incentives, neighbourhood information and knowledge, preconditions, structure and decision-making process. Observational reports were written and were discussed by the researchers. Emerging themes were integrated and led to a description of the features of the panels.
In-depth interviews

The two MHS health promoters (the chairs) and the involved municipal policy-makers were regularly interviewed (see Supplementary material online, Appendix S1). In addition, 10 panel members were invited to in-depth interviews. Purposive sampling was used to obtain a cross-section of the members and an insight into a broad range of personal perspectives. These members were invited based on the type of organization, neighbourhood, micro grant applications and frequency of attendance in the panels and were approached by telephone and e-mail. They were asked for their voluntary cooperation and were assured that their information would be assessed anonymously.

Interviews were conducted by two researchers (MS and TP). The interview guide used was informed by observations of the panels in 2005 and by literature about coalitions. The final list covered six topics: (i) position and organization; (ii) how respondents became involved in the panels; (iii) vision for the panels; (iv) community participation and intersectoral cooperation; (v) opinion on this municipal strategy to tackle health inequalities; and (vi) content of applications. Interviews were audio-taped and transcribed verbatim. To explore the perceptions of the respondents, we used an open approach to analyse the interviews. The programme MAXQDA was used to facilitate data coding.

Collecting and analysing documents

Micro grant recipients were asked to write a report for which a format had been constructed by researchers and policy-makers. It contained 26 items concerning (i) the background of their initiative, (ii) the process of realization and (iii) the outcomes. Of the 51 reports received, 38 used the format and 13 did not contain all the items. Ten initiatives did not provide records.

RESULTS

Health promotion initiatives

Although altogether the six panels granted 61 initiatives (see Supplementary material online, Appendix S2), only one spent the entire amount of money available in 2005. In 2006, nearly all the panels spent more money than in the previous year but four remained under the limit. The exception was Schilderswijk, which was able to exceed the limit through a transfer of budget from other neighbourhoods that were spending less (Table 1). Possibly, this was because this panel had the most members and enjoyed a history of neighbourhood activities in which workers already knew each other.

The majority of initiatives were directed at physical activity and nutrition and were occasionally combined with pedagogic support (Table 2). Initiative examples included cooking healthy food in the community centre, setting up exercise courses and becoming familiar with local facilities. The most frequently used communication channels were courses with multiple sessions in which participants learned skills like cooking or exercise (Table 2).

In 2005, one-third of the granted initiatives were financially sustained. In 2006, this applied to almost 50% of the initiatives. Of these 15, eight became self-sustaining through regular budget and contribution fees. Seven initiatives were financially sustained by other funds (albeit temporarily). There appeared to be a tension between the expectations of the policy-makers and applicants regarding this issue of financial sustainability. In the interviews, health and community workers expressed their concerns about the continuation of successful initiatives; they felt this was the responsibility of the municipality. However, the MHS health promoters argued that they could not be held responsible for this, as the number of initiatives was simply

<table>
<thead>
<tr>
<th>Neighbourhood</th>
<th>Total number of meetings</th>
<th>Mean number of participants per meeting</th>
<th>2005 Budget spent (in Euros)</th>
<th>2006 Budget spent (in Euros)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schilderswijk</td>
<td>4</td>
<td>10</td>
<td>25.896</td>
<td>25.230</td>
</tr>
<tr>
<td>Bouwlust</td>
<td>4</td>
<td>8</td>
<td>18.954</td>
<td>12.826</td>
</tr>
<tr>
<td>Laak</td>
<td>4</td>
<td>6</td>
<td>7257</td>
<td>12.397</td>
</tr>
<tr>
<td>Moerwijk</td>
<td>4</td>
<td>6</td>
<td>9106</td>
<td>13.047</td>
</tr>
<tr>
<td>ReVa</td>
<td>4</td>
<td>7</td>
<td>10.587</td>
<td>20.562</td>
</tr>
<tr>
<td>Transvaal</td>
<td>2</td>
<td>5</td>
<td>7197</td>
<td>13.883</td>
</tr>
</tbody>
</table>
too large to stay informed on (the successes) all of them. Besides, in contrast according to the formulated criterion by the MHS, applicants were supposed to generate possibilities to financially sustain initiatives themselves.

The distribution mechanism: neighbourhood health panels

In addition to the two MHS chairs, the panels consisted of health and community workers active in the neighbourhood, such as library workers, dieticians, social-cultural workers, community centre workers, youth health care nurses and pharmacists. The number of members varied per neighbourhood from 4 to 15 (Table 1), and most of the applications came from them. Only two external organizations applied for a grant. Individual residents were not directly involved in the applications; not being legal bodies, they were not able to apply on their own, nor were they represented in the panels by residents’ organizations.

In two panels, the meetings were attended only by applicants. Nevertheless, some members demonstrated commitment to the health panels by attending on a regular basis without ever applying for a grant. In one neighbourhood (Transvaal), the panels were stopped after two meetings due to too few participants.

It was observed that discussions about the applications were based on five main criteria: match with one of the action themes, empowerment, innovation, continuation and cooperation. However, the criteria were managed unsystematically. In some cases, for example, sustainability was interpreted as a kind of empowerment on the part of the participants, and in others, it was seen as financial maintenance of the initiative. Furthermore, the significance ascribed to the criteria fluctuated. Within some initiatives, the chair stated that participants should not expect the initiative to become ‘sustained’ but said ‘this should not stand in the way’. Other initiatives were returned to the applicants in order for them to rewrite their application on the point of sustainability. These deviations could be explained by the fact that the criteria were not described in a vision document by the municipality, nor was their meaning communicated to the panels. Furthermore, neither the interpretation nor the significance of the criteria was discussed among panel members; hence, the precise content of the criteria remained vague.

<table>
<thead>
<tr>
<th>Table 2: Theme and nature of the micro grant initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical activity</strong></td>
</tr>
<tr>
<td><strong>Skills training</strong></td>
</tr>
<tr>
<td><strong>Information</strong></td>
</tr>
<tr>
<td><strong>Community building</strong></td>
</tr>
<tr>
<td><strong>Facilitating</strong></td>
</tr>
<tr>
<td><strong>Positive feedback</strong></td>
</tr>
<tr>
<td><strong>Combination</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>
And sustainability, what does it mean? That the initiative is being connected to something else, or along those lines? [Resp. no. 4]

Also the criterium ‘innovative’ was interpreted differently by the participants. More specifically, respondents questioned the surplus value of this criterium and referred to previous successful initiatives that had to stop because of a lack of budget. Starting new initiatives while these ‘old’ initiatives were stabled was considered a shame. One other worker remarked that the criterion ‘innovative’ was just for show. This opinion was shared by one of the chairs, who had few expectations of the innovative character of the applications.

Innovative? Nonsense! I’ve worked in this field for years and I just invent a formulation, one that sounds innovative. [Resp. no.2]

There are already a lot of these kinds of activities in the neighbourhood; it is of course also a way of getting extra financial means. [Resp. no. 11]

Finally, observations and interviews with health and community workers showed that members’ perceptions were mixed when it came to judging the applications of their fellow neighbourhood workers. On the one hand, respondents were enthusiastic about the possibilities to actually say something about the proposals and about the fact that democracy was being brought back into the neighbourhood. On the other hand, some respondents were reserved during the meeting when it came to judging the applications critically; they mainly wanted to be supportive of each other. Others said they felt hesitant to judge critically when the proposals were not in their field of expertise.

What I think is difficult is when they ask you, for example, to critically judge an application by a primary school that wants to cook with children. [Resp. no. 2 Programme manager Refugee organisation]

However, most respondents experienced that the critical capacity to judging the applications somewhat increased over time. Observations revealed that the level of discussion increased as well, confirming the perceptions of the panel members.

The impact on mobilizing the community

Interorganizational collaboration

The micro grants catalysed network possibilities for the panel members by offering them a platform to meet new contact persons, to discuss their initiatives, to learn from each other and to increase their knowledge of what was going on in their neighbourhood.

I never knew that these kinds of activities existed for the elderly. [Resp. no. 4]

I think it is a good thing because you hear from each other what everyone is doing and because you learn from each other. [Resp. no. 8]

In addition, the health and community workers felt that the panels and the availability of the micro grants stimulated connections. Many respondents indicated that the collaboration the community workers were ready to collaborate, but were still looking for opportunities.

Collaboration has to grow, but everybody is trying and is open to the suggestion. [Resp. no. 2]

I didn’t start new collaborations, as I don’t have the time. But it would be possible with the community centre ‘de mussen’, for example. [Resp. no. 4]

Observation notes revealed the importance of chairs as mediators. They often took the lead in negotiations regarding possible cooperation between members, or connected the applicants to other workers in the field.

Commitment of the workers in the field to municipal activities on health promotion

The micro grants appeared to affect commitment in the field on two levels: (i) they served as a catalyst in setting an agenda of health issues and (ii) they provided the municipality with a network within the neighbourhood.

First, the micro grants appeared to serve as a catalyst of putting health issues and reducing inequalities on the agenda of both traditional and non-traditional health agencies. This alternative financing scheme attracted eight different types of organizations, including non-traditional health agencies; agencies that normally do not actively anticipate on health issues such as residents’ organizations (Table 3). Some health and community workers mentioned that the scheme inspired them to take action.

I have no knowledge of health-related issues. But if I hear that it can be simple and is close by, and I hear from others what they are doing, then I feel motivated and inspired to do something with the health topic as well. [Resp. no. 2]

One community worker told us that these initiatives opened doors within her own
Table 3: Mobilization of local organizations and residents

<table>
<thead>
<tr>
<th>Number of receivers of the grants per organizational type</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Welfare organizations</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>One-issue foundations</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Development organizations</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Other foundations</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Resident organizations and community organizations</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Regular healthcare providers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Schools</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Club</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Profit organization (event bureau)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Reached residents that attended the activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>01–20</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>21–50</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>51–100</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>≥100</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

organization in such a way that she expected the theme of health would subsequently receive more consideration. Another professional mentioned having an initiative in which ‘health issues’ were poorly represented but that the micro grants had created attention.

The issue of health was only moderately represented and not based on current practice. Now I’ve made the suggestion to bring it up to date. [Resp. no. 7]

Second, the micro grant applicants and the panels provided the municipality with a network. This network was useful to the municipality in order to organize their interactive policy-making. For example, the network was used to fine-tune the content of the white paper for Public Health 2007–2010 to the actual issues and needs in the neighbourhoods. The micro grants stimulated this networking in three ways. In the first, the health and community workers were motivated to join the panels in order to meet other workers and expanding their network. In the second, MHS health promoters impressions were that the municipality became more approachable due to the regular contacts involving grant applications. They believed that the health and community workers they met were eager to hear from them how things ‘work’ within the municipal organization. Third, the community workers were motivated because of the mere fact that money was available through which actual ‘something could be done’. Money (or grants) serving as a carrot to create networks was one of the main goals of the municipality.

My most important idea was to give the MHS health promoters a position in the field. The idea was that these are people you can do business with. This was important in order to get input from these workers on what is going on in the neighbourhoods. And if you want to organise something, you can easily use the network that was created. Yes, it is about buying support. (Resp. no. 14)

Activities that respond to the actual needs of the residents

In the interviews, health and community workers expressed a wish to connect, in their everyday work, with their target group. Although not all panel members, such as the pharmacists, were directly in contact with their target group, in general they felt that operating in this manner helped them to tailor the initiatives to residents’ needs.

An advantage is that you are working close to your target group; you have got a lot of contact, get a lot of information. Changes in the society are immediately noticeable. [Resp. no. 1]

However, it appeared that residents were not always the direct stimulus for new initiatives. Health and community workers started the initiatives based on various signals, ranging from needs mentioned directly by the target group (in the library or community centre) but also on indirectly communicated needs via school teachers or newspapers. Then, when applications were discussed, there was, likewise, little attention for the involvement of residents; and then more focused on attendance rather than involvement in the development of initiatives. These observations that the issue of participation of residents was not elaborated were confirmed by the chairs, who had the impression that health and community workers often suggested their own ideas.

You never know if it really addresses the problems of the target group or their needs. The municipality thinks we know everything. [Resp. no. 2]

The activities did motivate many residents to attend, and most initiatives reached up to 50
residents (Table 3). However, the intended actual public participation was low. Of the 61 initiatives, 21 reported having involved residents in the development of the activity. Eighteen initiatives reported not having involved residents. For 23 initiatives, the result was not clear. Most applicants, however, considered the level of participation satisfactory. They felt attendance in the initiatives was an enormous step for certain target groups, such as those who were really isolated. For them, public participation was, for example, operationalized as visiting a neighbourhood health institution.

It seems basic, but I experienced that for a couple of women it was literally the very first time that they had ever used a street-car. It’s that basic in these neighbourhoods. [Resp. no. 3]

Other workers (e.g. the pharmacists) said they did not work with the concept of community participation or they still struggled with the concept of ‘public participation’ in relation to the development of activities.

Involve the residents? I find that difficult. How do you involve residents? [Resp. no.7]

It is a nice idea when it originates from residents […] [but] if they were to do it, I wonder how that would go. [Resp. no. 1]

**DISCUSSION**

This study demonstrated that micro grants are a viable means to enable community action. The scheme facilitated a considerable number of initiatives, enabled commitment and set an agenda for health issues. However, on actual interorganizational action and public participation, certain limitations were seen.

**Commitment/setting an agenda for health**

The availability of grants, served as an incentive for workers to join the panels in which the micro grant applications were discussed. The community workers developed skills and experience through increased networking and information sharing. These are considered crucial steps in the process of activating communities (Bracht et al., 1999). The power of the panels with regard to learning was however not fully exploited. The workers were reserved in being critical on each others work. Concurrently, the intention to learn from each other was hampered. A judgement by independent workers or anonymous reflection on the proposals might be helpful. Nevertheless, the network fuelled a process in which health inequalities entered the agenda of a variety of organizations and increased commitment with regard to related municipal activities. In accordance with evaluations of other micro grant programmes (Bobbitt-Cooke, 2005), this scheme has been seen to attract organizations from multiple sectors. This is important, since improving community health goes beyond the capability and resources of any single sector. Because of the limited number of conditions that accompanied the granting process, the municipality was able to adapt to existing agendas and priorities. This is significant in the public health sector (Milio, 1998), as different departments have diverse and occasionally even conflicting priorities (van Herten et al., 2001).

**Interorganizational collaboration**

The actual collaboration between health and community workers was limited. This could be due to the initial stage of development of the panels. However, the municipality could have supported the health panels on this point more thoroughly, e.g. by making the fundamental set of collaboration issues an agenda point. In the panels, a common definition of the problem, identification of resources and establishing ground rules were not addressed in the panels. The absence of these generic issues in the discussions that generally precede collaboration activities (Gray, 1989) limited possibilities to sustain collaboration. Besides, actual collaboration could be hampered by the fact that the panel members were competitors in the granting process. The municipality might tackle the competitive elements by making collaboration a requirement for obtaining a grant.

**Public participation**

Community and health workers were able to experiment with small-scale initiatives in which they were able to respond to needs of specific and small resident groups that are normally difficult to reach. According to the applicants, the attendance of residents in these initiatives was a first step to actual participation. This could be considered an alternative to the top-down approach, which has failed to resolve many
local problems (Lasker and Weiss, 2003). Participation is known to have certain predisposing factors, such as sufficient awareness, and knowledge and skills (Zakus and Lysack, 1998).

Nevertheless, it appeared to be a challenge for the workers to turn this attendance into actual resident participation. Although resident participation was an important aim, the lack thereof could be explained by the governance of the municipality: namely, the residents were not directly represented by their own organization; they were not able to apply for grants on their own behalf; and there was no vision developed on how to involve them in the application and development of the initiatives. The support of the administrative system is important for participation (Zakus and Lysack, 1998; Boyce, 2002). Workers could be trained, for example, in certain skills needed to maximize public involvement (Maloff et al., 2000; PAULO, 2003; NICE, 2008). Another way to stimulate participation is to open the micro grant scheme to residents. Other studies have demonstrated that support by neighbourhood outreach workers, functioning as ‘connectors’, does help in applying for grants (Foster-Fishman et al., 2006).

Confusing objectives

The objectives of the scheme were formulated rather loosely, leaving room for different interpretations of goals and criteria. Apart from the aforementioned concept of community participation, two prominent examples are the concepts of innovation and sustainability. First, the mere formulation of the criterion ‘innovation’ seemed in this project not to have resulted in innovative initiatives. The criterion ‘innovation’ was not considered an important goal, by the community workers, as existing successful initiatives had to be stopped because of a lack of financial means. As a result of this confusion some workers became sarcastic about the criteria which cannot be considered constructive. In order for the micro grant scheme to be effective, it seems necessary to elaborate on goals and criteria together with the health and community workers. They can help to tune the criteria to their daily practice.

Second, the criteria of sustainability were surrounded by vagueness. If the micro grant scheme is about planting ‘seeds’ in order to see what might be effective in health promotion, the municipality should organize a ‘chain of research and development’ in which successful initiatives are identified and widely implemented. This responsibility can explicitly given to the field by making the workers more responsible for sustainability by stimulating ownership for example. Applicants could be motivated to mobilize additional community resources. An example of this was seen in the Healthy Carolinians Partnerships, in which micro grants were supplemented by resources that each organization contributed to the project (Bobbit-Cooke, 2005). A criterion of the programme could be that the applicants must contribute in-kind labour for each grant they receive.

A limitation of this study is that reports of the initiatives were not all received (or not in the right format). This restricted the available information. Normally, the receivers of municipal grants up to 50 000 are not asked to writing such a report. Furthermore, the panel members were not managers but workers of at the operational level. They are not used to write these kinds of reports. Our experience suggests that in order to obtain full insight into these kinds of initiatives, one should not rely on administrative forms filled out by those who carry out the projects. Instead, additional data collection seems to be necessary, such as oral interviews among the fieldworkers. Furthermore, the results cannot be contextually generalized to other countries since they may differ in the conditions described in this paper, including the possibilities of structural funding and the competences of community workers. We nevertheless hope that the lessons we learned might be useful for those who want to develop similar interventions.

CONCLUSION

This case study provides evidence to suggest that micro grants have the potential to stimulate community action at an organizational and a residential level. The availability of grants is supportive but not sufficient, hence we need other ‘things’ to organize a successful chain of action through which successful projects are recognized and are more widely implemented and to organize public participation. Therefore, in order for micro grants to be optimally effective, they must be accompanied by investments in infrastructure such as training of professionals, supporting professionals in initiating collaboration and providing information on how to obtain structural funding.
SUPPLEMENTARY MATERIAL

Supplementary material is available at Health Promotion International online.

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