Challenges Evaluating an Equity-Focused Community Coalition Initiative

Nicole M. Augustine
RIZE Consultants, Charlotte, North Carolina, United States

Jill A. Chouinard, Ph.D.
University of Victoria, Victoria, British Columbia, Canada

Abstract: *In this practice note, the authors reflect on their experiences evaluating a three-year behavioural health equity initiative that was conducted with eight community coalitions located across the southeastern United States. The main focus of the practice note is on the challenges the authors experienced in their evaluation, most of which were largely outside their control: unpredictable funding cycle, complexity of problem, level of local knowledge, level of data literacy, and collaborative approach not realized. While they acknowledge the complexity of behavioural health equity issues, they conclude with four key implications for practice that they note can help relieve the stress of some of the challenges they experienced.*

Keywords: *health equity, community coalition, equity*

Résumé : *Dans la présente note de pratique, les autrices réfléchissent à leur expérience d'évaluation d'un projet d'équité en santé comportementale réalisé avec huit coalitions communautaires dans le sud-est des États-Unis. La note de pratique traite principalement des défis que les autrices ont eu à relever dans le cadre de leur évaluation, dont la plupart étaient hors de leur contrôle : cycle de financement imprévisible, complexité du problème, niveau de connaissances locales, niveau de littératie en matière de données et problèmes dans l'approche collaborative. Les autrices reconnaissent la complexité des questions d'équité en santé comportementale, mais elles présentent quatre conclusions clés pour la pratique qui pourraient aider à atténuer le stress lié à certains des défis encourus.*

Mots clés : *équité de santé, coalition communautaire, équité*

> *Above all, on humanitarian grounds national health policies designed for an entire population cannot claim to be concerned about the health of all people if the heavier burden of ill health carried by the most vulnerable sections of society is not addressed.*
> (Whitehead, 1991, p. 218)

Corresponding Author: Nicole Augustine, 10130 Mallard Creek St, STE 300, Charlotte, North Carolina, United States, 28262; nicole.augustine@rizeconsultants.com

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INTRODUCTION

Health disparities are widespread in our society, disproportionately affecting individuals, families, and communities that systematically experience social, economic, and cultural disadvantage. While health disparities are located in a diversity of racial and ethnic groups, historically these populations have experienced reduced access to health care and higher barriers to service use, leading to elevated levels of mental and substance use disorders, higher rates of suicide, poverty, domestic violence, and childhood and historical trauma, as well as involvement in the foster care and criminal justice systems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Moreover, racial and ethnic minority groups both in Canada and the United States are disproportionately being affected by COVID, a reality that draws attention to the systemic nature of the inequities that already exist and that COVID has made more obvious (Price-Haygood, Burton, Fort, & Seoane, 2020; Stokes, et al., 2020). At its core, the concept of health disparities is about social justice—justice as it pertains to the treatment of advantaged versus less advantaged (and historically marginalized) people in terms of health care (Braveman, 2014).

As Whitehead (1991) describes, health inequities are "differences in health which are not only unnecessary and avoidable, but in addition, are considered unfair and unjust" (p. 5). Research on health inequities identifies the impact of culture in shaping perceptions of health and the health-care system. People from minority cultural and linguistic backgrounds often receive poorer-quality care compared with majority populations and are more likely to experience negative and sometimes life-threatening experiences as a result of poor communication or other linguistic or cultural barriers, a reality that is true in Canada as well as in the United States (Horvat, Horey, Romios, & Kis-Rigo, 2014; Lasser, Himmelstein, & Woolhandler, 2006). Researchers have noted the lack of progress and measurable improvements being made in addressing health disparities, attributable in part to "siloed" approaches to addressing this complex issue (Horowitz & Lawlor, 2008).

Across North America, community coalitions, defined as "groups of individuals, factions, and constituencies who agree to work together to achieve a common goal" (Butterfoss, 2006, p. 328), are being created to address a broad range of complex public health issues. Depending upon the issue and community involved, the structure and intent of coalitions can vary significantly, from informal networks to loose or tight partnerships, strategic alliances, or joint ventures (Reid et al., 2019). While there are a number of different foci for coalitions (e.g., environmental, health, mental health, addiction, etc.), community coalitions that engage on issues of equity/health equity and justice involve a specific focus for community coalitions that includes systems change, grassroots organizing, local leadership capacity building, a focus on sustainability through evaluation and program planning, and community ownership (Wolff et al., 2016). As Minkler, Rebanal, Pearce, and Acosta (2019) argue, "if public health professionals want to get to health equity, we must start with more fundamental issues of race-based

oppression and social justice" (p. 125). In this practice note, we reflect on our challenges evaluating a three-year behavioural health equity initiative that we conducted with eight community coalitions whose work focused on identifying and addressing a health disparity within their community. We begin with a brief description of the initiative and the approach to evaluation. Our main focus is on key challenges we experienced as evaluators of this initiative.

THE BEHAVIOURAL HEALTH EQUITY INITIATIVE

The behavioural health equity initiative was a three-year project designed to build capacity and provide technical and financial support to eight participating community coalitions. Community coalitions were responsible for partnering with community members, agencies, and organizations in identifying a critical health disparity and developing and implementing strategies to effectively address their identified disparity. The funder provided each coalition with annual funding, technical support, and equity and technical training.

The first year of the initiative was focused on developing the skills and capacity of community coalitions to conduct a community needs assessment as a means of properly identifying a context-specific behavioural health disparity. The second year was focused on improving the community's capacity to address health disparities and implementing an action plan to address the defined health disparities. During the final year of the project, the community coalitions continued with implementation and worked to articulate the outcomes and lessons learned. While all the eight participating community coalitions identified their own context-specific health equity concern based on a prior community needs assessment, despite differences in identified populations (some selected LGBTQ youth, Black youth, youth of colour), there were common themes identified across coalitions (e.g., focus on trauma and resilience, community readiness, building partnerships, and community leadership).

PROGRAM EVALUATION APPROACH

The evaluation approach for this initiative was informed by the sociocultural context of the program and was designed to ensure that planning, design, implementation, and outcomes were grounded in the local knowledge and cultural histories of the program and communities involved. As such, we used a collaborative approach, working closely with the project team to design, implement, and write up the evaluation. The purpose of the evaluation was to capture coalition experiences, challenges, and successes over the three-year period of the initiative, with findings intended to be used formatively to inform the future planning and implementation of the initiative in subsequent iterations. As such, evaluation questions, cowritten with the evaluation team, were designed to solicit perspectives on (a) the experiences of participating sites, focusing on challenges and areas of success; (b) understanding the extent of program sustainability and accompanying

successes and challenges; and (c) overall satisfaction with support and range of local needs. In what follows, we describe the challenges we encountered in our evaluation of this initiative.

IDENTIFIED CHALLENGES

While we recognize that these challenges are not unique to this initiative, the conflation of all five challenges speaks to the complexity of the issues across these eight community coalition sites, as well as the need to keep a specific focus on equity in all community coalition work.

Unpredictable funding cycle

Although this was a three-year project, the funding allocation from the state funder was issued in one-year increments. Moreover, annual funding was often delayed by months, during which time coalitions could not submit their monthly invoices for work completed. This funding cycle caused considerable challenges for community coalitions, who often did not have sufficient funds to sustain their projects while awaiting funding from the state. In other words, community coalitions would need the capital necessary to cover expenses while awaiting their reimbursement. As a result, funding delays caused significant momentum issues in the implementation of the project as activities were delayed until official notification of the allocation of funds was received. And unfortunately, the university was unable to reimburse the participating communities until they had received a formal allocation letter.

Annual allocation was also not predictable, as there was wide variation in when and how quickly the allocation letter arrived. In the first year, there was a three-month delay, which retrospectively did not cause too much concern with the coalitions. However, during subsequent years there were more significant funding gaps that significantly impacted implementation at the local levels. While some communities had the financial capital to continue their work, others had to pause activities until they had received the official word on the allocation of funds. This created a difference in the level of productivity among participating coalitions, a difference that also affected the delivery of technical assistance and training, given that each community was at a different stage of implementation.

Complexity of the problem

Health equity is a complex social problem that requires environmental/social change. It requires the evaluation of structural and institutional discrimination and the reallocation of resources to overcome social inequities (Minkler et al., 2019; Reid et al., 2019). The process of assessing, planning, implementing, and evaluating such a change requires time and money—in fact, much more time and money than what was allocated for this project. In year one, the communities received $12,000, followed by $18,000 in year two and $22,000 in year three. This

level of funding has not shown to be sufficient to address the complex problem of behavioural health disparities.

The complexity of the problem also created difficulties in our ability to measure impact. When the bar for change is the dismantling of structural and institutional discrimination, how do you measure impact based on lower-level activities that are leaps and bounds away from creating environmental change? How can one say that a youth photovoice project contributes to reducing the behavioural health disparities in a community? Or that a public showing of the movie *Resilience* has any impact? The complexity of the problem also made it difficult to develop a uniform evaluation approach across all eight sites, as each community identified a unique behavioural health disparities that required a custom evaluation plan, making it difficult to create comparison on progress between the communities.

Level of local knowledge

This was a pilot project, and thus the communities and leadership were simultaneously "building the plane as they flew." When asked specifically about challenges experienced over the past three years, many of the site coordinators mentioned the lack of guidance and structure for the first year of the project, resulting in the need for them to figure out how to do the work and identify manageable short-term outcomes, as well as how to define behavioural health equity or diversity.

Additionally, the nature and depth of the health equity issue they selected required substantial individual and local capacity building to an extent greater than anticipated. For some, this meant starting at the grassroots level and focusing on community readiness. For example, a site identified LGBTQ youth as having significant behavioural health disparities. However, this community is conservative, and the site coordinator was unable to even initiate a conversation about the health equity issue given the level of bias identified at the individual and institutional levels. The degree to which this challenge affected each site was dependent on the level of local knowledge and community readiness.

Level of data literacy

Data literacy varied significantly across all eight sites, with some quite adept at collecting and analyzing qualitative and quantitative data and others unable to create action plans with measurable goals or identify outputs and short-term objectives. While some of the sites worked directly with an evaluator, others persisted in completing the work alone, with little community input. As a result, the identification of community needs, as well as the use of measurable action plans to focus their work, was missing. The lack of data literacy also made it challenging for coalitions to partner with other local organizations, as they lacked the language, concepts, and facility to engage in discussions about collective need. More importantly, while the majority of the eight coalitions were working with communities and populations that were systemically marginalized, their methods and approaches

were not specifically tailored in culturally responsive ways and in ways that might best the cultural context of their communities.

Collaborative approach not realized

The success of community coalitions rests on participatory and collaborative principles in terms of the community needs assessment process, coalition governance, and evaluation. Collaboration and sustainability go hand in hand (SAMHSA, 2011). For many of the coalitions, there were challenges identifying community stakeholders who might be interested in participating in the initiative. For some, this challenge was related to the large geographic size of the region, while for others it was related to a lack of resources, slow momentum or interrupted momentum with project start-up, or potential cultural barriers to inclusion and a lack of perceived capacity in the community.

IMPLICATIONS FOR PRACTICE

While there were numerous challenges identified throughout this three-year initiative, it did shed light on the structural, social, and political complexity of health equity issues. Based on our experiences, we have identified five practical implications, or lessons learned, as we now move into a second iteration of this initiative.

1. Account for funding delays in the project timeline. In year three, we embedded a three-month delay into the project timeline, which reduced the project implementation timeline from one year to nine months. This provided grace for sites that did not have the capital to operate for an extended period of time without funding. A focus on building a more diverse partnership base might also have helped broaden the funding base and open up future grant possibilities (Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010).
2. Strengthen skills in data literacy. A sound understanding of data is crucial to identifying behavioural health disparities. Greater effort should be put on developing the skills of prevention in collecting, analyzing, and communicating behavioural health data. This training and technical assistance should intentionally include skill development in culturally responsive approaches (Domlyn & Coleman, 2019).
3. Develop a standard behavioural health community needs assessment. There was wide variance in the availability of data to effectively describe a community's behavioural health disparity. The development of a standard survey to be used for the initiative would create consistency in the access to data across all sites.
4. Develop knowledge and understanding of health equity. The complexity of the problem requires a shift toward systems and organizational change. Without this shift, communities seem to default to developing strategies focused on individuals versus strategies of a more environmental nature (Hilgendorf, Moore, Wells, & Stanley, 2020).

5. Ensure that community coalitions actively include people who share the lived experience of their target populations. For many of the coalitions, this was simply never realized, and as a result, they spent much of their time focused on establishing cultural credibility with potential community partners. Another result was the lack of focus on building community capacity and developing leadership among the local population (Minkler et al., 2019), all of which might have helped build sustainability for local initiatives.

CONCLUSION

In this practice note, we shared our experiences evaluating a three-year behavioural health equity initiative, focusing on our challenges and lessons learned. While some of the challenges we experienced can be addressed by ensuring more consistent funding and through focused training of site coordinators (and other participants) on issues of equity and collaboration and data literacy, it is also important to note that health equity is fundamentally an exceedingly challenging and systemic problem—what some would call a "wicked problem." As such, community-based researchers and evaluators have begun weaving together issues of equity, justice, and systems thinking to address the complexity, depth, and systemic nature of the issues involved (see Bryan et al., 2014; Hilgendorf et al., 2020; Wolff et al., 2016), all of which become critical considerations in framing culturally appropriate evaluation approaches in these contexts.

At the same time, a number of factors have been identified that make community coalitions themselves (notwithstanding the issues they are working on) difficult to evaluate: There are many organizations involved and numerous interventions staggered over time (Kreuter, Lezin, & Young, 2000); there is a lack of understanding about interrelationships among stages of development (Granner & Sharpe, 2004); it is challenging to evaluate the evolution of the coalition and compare results across communities (Granner & Sharpe, 2004); and there are few measures to assess the stages of development and the potentially wide range of impacts across the community (Goodman, Wandersman, Chinman, Imm, & Morrisey, 1996).

As our experiences highlight, initiatives focused on health equity, especially those located in dynamic community coalition contexts, require a culturally responsive and multimodal and multilayered approach to evaluation that can capture and convey the depth, breadth, and complexity of these equity-focused initiatives from the ground up. As Whitehead (1991) stated, "Solving problems of inequity cannot be achieved by one level of organization or one sector but has to take place at all levels and involve everyone as partners in health to meet the challenges of the future" (p. 442). Understanding and identifying the systems that scaffold inequities can help ensure that evaluation does not maintain and support the structures and systems that gave rise to the inequities in the first place but rather that it can challenge our understanding and appreciation of what real equitable change can and should look like in our society.

REFERENCES

Braveman, P. (2014). What is health equity: And how does a life-course approach take us further toward it? *Maternal and Child Health Journal*, *18*(2), 366–372.

Bryan, V., Brye, W., Hudson, K., Dubose, L., Hansberry, S., & Arrieta, M. (2014). Investigating health disparities through community-based participatory research: Lessons learned from a process evaluation. *Social Work in Public Health*, *29*, 318–334.

Butterfoss, F. D. (2006). Process evaluation for community participation. *Annual Review of Public Health*, *27*, 323–340.

Butterfoss, F. D., & Francisco, V. T. (2004). Evaluating community partnerships and coalitions with practitioners in mind. *Health Promotion Practice*, *5*(2), 108–114.

Domlyn, A. M., & Coleman, S. (2019). Prioritizing equity: Exploring conditions impacting community coalition efforts. *Health Equity*, *3*(1), 417–422.

Fawcett, S., Schultz, J., Watson-Thompson, J., Fox, M., & Bremby, R. (2010). Building multisectoral partnerships for population health and health equity. *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, *7*(6), 1–7.

Goodman, R. M., Wandersman, A., Chinman, M., Imm, P., & Morrisey, E. (1996). An ecological assessment of community based interventions for prevention and health promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology*, *24*(1), 33–61.

Granner, M. C., & Sharpe, P. A. (2004). Evaluating community coalition characteristics and functions: A summary of measurement tools. *Health Education Research*, *19*(5), 514–532.

Hilgendorf, A. E., Moore, T. R., Wells, A., & Stanley, J. (2020). Positioning health equity within a systems thinking framework to evaluate coalitions and collaborative initiatives. In A. W. Price, K. K. Brown, & S. M. Wolfe (Eds.), Evaluating community coalitions and collaboratives [Special issue]. *New Directions for Evaluation*, *165*, 91–102.

Horowitz, C., & Lawlor, E. F. (2008). *Challenges and successes in reducing health disparities: Workshop summary*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12154.

Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals [Review]. *Cochrane Database of Systematic Reviews*, Issue 5. Art. No.: CD009405. DOI: 10.1002/14651858.CD009405.pub2.

Kreuter, M. W., Lezin, N. A., & Young, L. A. (2000). Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Pra*ctice, *1*(1), 49–63.

Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status, and health disparities in the United States and Canada: Results of a cross-national population-based survey. *American Journal of Public Health*, *96*(7), 1300–1307.

Minkler, M., Rebanal, R. D., Pearce, R., & Acosta, M. (2019). Growing equity and health equity in perilous times: Lessons from community organizers. *Health Education & Behavior*, *46*(1S), 9S-1-BS.

Price-Haygood, E. G., Burton, J., Fort, D., & Seoane, L. (2020). Hospitalization and mortality among Black patients and White patients with Covid-19. *New England Journal of Medicine*, 382, 2534–2543.

Reid, A., Abraczinskas, M., Scott, V., Stanzler, M., Parry, G., Scaccia, J., . . . Ramaswamy, R. (2019). Using collaborative coalition processes to advance community health, well-being, and equity: A multiple-case study analysis from a national community transformation initiative. *Health Education & Behavior*, *46*(Suppl. 1), 100S–109S.

Stokes, E. K., Zambrano, L. D., Anderson, K. N., Marsden, E.P., Raz, K., Felix, S.E.B., Tie, Y., & Fullerton, K.E. (2020). Coronavirus disease 2019 case surveillance—United States, January 22–May 30, 2020. *Morbidity Mortality Weekly Report*, *69*, 759–765.

Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of national findings* (NSDUH Series H-41, HHS Publication No. [SMA] 11-4658). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International*, *6*(3), 217–228.

Wolff, T., Minkler, M., Wolfe, S. M., Berkowitz, B., Bowen, L., Butterfoss, F. D., & Lee, K. S. (2016, Winter). Collaborating for equity and justice: Moving beyond collective impact. *Nonprofit Quarterly*, 42–53.

AUTHOR INFORMATION

Nicole M. Augustine is the Founder & CEO of RIZE Consultants, Inc, a strategic consulting firm founded in January 2015. Nicole is an entrepreneur, public health professional and social justice advocate. Her journey in public health began at Cornell University when after graduating she worked for three years as a BASICS counselor for Cornell's campus harm reduction initiative. From there, Nicole transitioned into the George Washington University School of Public Health before experiencing a rapid career progression from providing prevention education to providing training and technical assistance to communities, professionals and state agencies. In August 2022, Nicole published the Prevention Specialist Exam Study Guide to help readers understand the competencies and knowledge necessary to become a Prevention Specialist (PS) and adequately prepare prevention professionals to pass the Prevention Specialist certification exam.

Jill A. Chouinard, Ph.D., is an Associate Professor in the School of Public Administration. Her main research areas are in culturally responsive approaches to research and evaluation, participatory research and evaluation, and evaluation and public policy. Much of her evaluation work has been conducted in culturally and socially diverse community settings, where she has extensive experience leading evaluations at the community level in the areas of education, social services, public health, and organizational learning and change. She positions evaluation as a catalyst for learning, collaboration, equity, social justice and community change.