**COMMUNITY PERSPECTIVE**

# Equitable Partnerships Between Community-Based and Traditional Public Health Organizations: Recommendations from the Field

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**ABSTRACT**

The purpose of this brief report was to qualitatively explore barriers to fostering equitable partnerships between Community-Based Organizations (CBOs) and Traditional Public Health (TPH) groups, and to provide interviewee-driven recommendations. We conducted semi-structured interviews from February-June 2019 with representatives from CBOs (n=9), TPH groups (n=12), and the Praxis Project (n=2). We utilized thematic analysis with a priori categories (e.g., barriers) and themes being allowed to emerge within the categories. Interviewees discussed group tensions arising from power dynamics, initial distrust, and inherent differences. Also, the TPH-dominated funding landscape reportedly caused issues for CBOs, such as mission distortion, inequitable funding distribution, and lack of long-term funding. Interviewees suggested several potential solutions such as personal relationship building, addressing power dynamics, and inclusive funding agenda-setting processes. Those working in public health can follow the practical guidance presented in this study and others to foster equitable partnerships with communities and the CBOs that represent them.

**KEYWORDS:** Community health partnerships, Health promotion, Process issues, Power sharing, Community health research

## BACKGROUND AND PURPOSE

Health inequities continue to persist in the United States (U.S.).[1] Community-engaged actions can play a critical role in addressing systemic issues and promoting health equity.[2] Such initiatives often involve multi-sectorial collaboration, including groups referred to in this study as community-based organizations (CBOs) and traditional public health (TPH) groups. The term CBOs is used in this study to signify grassroots organizations, community organizing groups, and base-building organizations, among others, that typically aim to achieve community-driven goals.[3] The term TPH groups is used in this study to signify organizations such as governmental public health organizations, philanthropic foundations, and research or academic institutions. Although TPH groups may vary in size and scope, they are typically larger organizations that serve a broader geographic area compared to CBOs. However, a primary distinction made in this manuscript is that generally, CBOs originate potential solutions to public health issues based on expressed needs and wants of communities affected by the issue, while TPH groups originate potential solutions from established practice and a priori doctrine.

CBOs and TPH groups can bring complementary skillsets, and effective partnership may lead to increased efficacy for initiatives overall. TPH groups are relatively well resourced, staffed, and often possess technical expertise (e.g., statistical analysis), while CBOs often have expertise related to what matters to, and what works in, their community.[4] TPH groups have increasingly recognized that forming partnerships with CBOs is necessary to advance health equity, but both have often found it difficult to establish and sustain partnerships.[5]

The purpose of this brief report was to qualitatively explore barriers to fostering equitable partnerships between CBOs and TPH groups, and to provide interviewee-driven recommendations.

## METHODS

This study was part of a larger evaluation of the Praxis Project (Praxis). Praxis provides training, technical assistance, and peer-learning opportunities to national, state, and local partners (both CBOs and TPH groups) to guide, mobilize, and support organizations that are working to advance health equity and social justice. The Institutional Review Board for Human Subjects Research of [REDACTED FOR PEER-REVIEW PROCESS] deemed this study exempt from review. All prevailing ethical standards in protecting human subjects were followed.

We conducted 30-60 minute, semi-structured interviews in-person (n=1) and via telephone (n=22), from February-June 2019. Potential interviewees (n=30) were identified based on having a previous working relationship with Praxis (this was necessary to complete the objectives of the larger evaluation study) and selected for the sub-study based on an organizational mission that included advancing health equity, classification as a CBO or TPH group or Praxis, and having experience in multi-sector initiatives or partnerships involving CBOs and TPH groups. Potential interviewees were recruited via email and 23 agreed to participate. Interviewees included representatives from CBOs (n=9, from nine different organizations), TPH groups (n=12, from ten different organizations), and Praxis staff (n=2). CBO interviewees were in director-level positions (n=6) and coordinator level positions (n=3). CBOs worked in various geographies including city-level (n=5), tribal (n=2), regional (n=1), and national (n=1). All CBOs included

health equity as a focus area and many worked on other issues as well such as civic engagement, food access, environmental issues, labor rights, immigration reform, and housing justice. TPH interviewees were in director-level positions (n=4), program officers overseeing grant programs and funded projects (n=4), or were leading public health programmatic and/or research initiatives (n=4). TPH interviewees represented national-level (n=8) and state-level (n=2) organizations. All TPH groups included advancing health equity as part of their mission and the organizations included national research/advocacy groups (n=5) and philanthropic organizations (n=3), and state-level public health departments (n=2). Praxis staff interviewee titles were not provided to protect confidentiality, but both had relevant experience working with CBOs and TPH groups in health equity focused initiatives. There were not known between-group relationships across the CBO sub-group and TPH sub-group interviewed for this study; and further, interviewees were not made aware of each other's involvement in the study.

The study authors collaborated (including a Praxis researcher who understands both the CBO and TPH perspective) to develop interview questions for this study (these were a sub-set of the interview guide used for the larger evaluation study). Interviewees were asked about their experiences with, and recommendations for CBO-TPH partnerships.

Primary interview questions included:

1. Would you describe how [partnerships between CBOs and TPH groups] are typically initiated?
2. Would you describe your organization's experiences, both positive and/or negative with these types of partnerships?

3. What is your organization's typical role in these partnerships? And what is the typical funding arrangement for these partnerships?
4. What is needed to make these partnerships mutually beneficial?
5. Would you describe any barriers or challenges that you/your organization has faced with these types of partnerships that may have prevented it from being mutually beneficial?
6. What organizational characteristics make a good partner in these types of partnerships?

Interviews were audio recorded and transcribed verbatim. Interviews were conducted until thematic saturation was reached. To study the phenomenon of CBO-TPH partnerships, we utilized a thematic analysis incorporating Creswell's "lean coding" technique.[6] Themes within a priori categories (e.g., barriers and recommendations) were allowed to emerge inductively. A coding guide was created in three iterative steps. First, researchers independently read and open-coded randomly selected interviews. Next, researchers met to discuss the open coding, emergent themes, and relationships between themes. This led to an initial list of codes for themes and sub-themes. Finally, the research team coded the transcripts using NVivo qualitative analysis software and met to discuss the adequacy of the coding list – modifying as necessary (e.g., recategorizing, combining, and removing codes). A member checking was conducted by one of the Praxis interviewees who is familiar with both the CBO and TPH perspective. This interviewee read and endorsed the findings of this study.

## RESULTS

The sample was racially/ethnically diverse and included 18 women and 5 men. Key themes and recommendations for CBO-TPH partnerships and funding relationships are described below. TPH and CBO interviewees shared similar views with respect to the following themes.

***Causes of CBO-TPH Partnership Tensions***

Interviewees described sources of tension to be power dynamics, initial distrust, and inherent differences. TPH groups often led initiatives and distributed funding, while CBOs assumed a subordinate role. CBOs felt their abilities were often underappreciated in multi-sectorial partnerships. For example, CBO interviewees perceived that their organizations were often underfunded and/or they did not have the same level of decision-making power relative to other partners. TPH groups reported distrust of CBOs, such as doubting their technical and organizational capacity. Conversely, CBOs perceived TPH groups' goals were often to get data and advance careers, rather than create sustained positive change in communities. One CBO interviewee described a partnership that soured when a university researcher declined to attend and show support for a community advocacy event, *"…why on Earth am I wasting my time partnering with someone who cannot even get out of this little comfort zone? … they are going to run amazing statistical models… but I choose my partners based on who can actually be an ally." (CBO).* Other tensions conveyed related to inherent differences in use of language and differing epistemological grounding. CBOs were described as having a culturally nuanced understanding of issues, while TPH groups sometimes lacked cultural humility. Also, TPH groups were reported to rely on rigorous scientific knowledge, whereas CBOs were more likely to assign equal or greater weight to experiential knowledge. A TPH interviewee explained the need to weigh experiential and scientific knowledges as, *"I think on the institutional side there*

*has to be some cultural humility. I think you have to understand that there are different kinds of evidence and the experiences of people [who] live in that environment [where] you're likely to die sooner and live sicker. That has to take some precedence over book learning. And if you can establish that mutual respect and understanding the different types of knowledge that need to be brought to bear solve the problem, I think that goes a long way." (TPH).*

***CBO Issues with TPH-Dominated Funding Landscape***

Interviewees discussed CBO issues resulting from the TPH-dominated funding landscape, which included mission distortion, inequitable funding distribution, and lack of long-term funding. TPH groups typically develop funding agendas without input from CBOs which can reportedly lead to a misalignment between funding objectives and community needs, and pressure CBOs (who often operate with limited resources) to deviate from their missions. A TPH interviewee described this as, *"... because of the power disparity, philanthropy wins and grassroots groups sometimes contort themselves in order to get funding to do what the foundation wants." (TPH).* Interviewees also conveyed that funding disparities exist across the CBO landscape. For example, interviewees felt that high-capacity CBOs get funded disproportionately, which leaves little funding for lower-capacity CBOs to sustain themselves or grow. Also, this gap was seen as being exacerbated by the considerable resources required for developing competitive funding proposals, which over time deplete resources of smaller CBOs. Finally, CBOs sought systemic change through educating and building civic power to address issues – a long-term process that is difficult to measure objectively. However, many funding opportunities were seen as supporting short-term, "one off" targeted projects with strict outcome measurement requirements.

***Recommended Approaches to Address these Issues***

Interviewees suggested several potential solutions to address group tensions and promote mutually beneficial collaboration within multi-sector public health initiatives.

Interviewees' recommendations related to group tensions included:

A. Ensure TPH groups have an understanding of the communities they are working with, through training, or by staffing with personnel from similar backgrounds as the community.
B. Plan upfront time to foster personal relationships and build trust between personnel from TPH groups and CBOs.
C. Establish through an inclusive process, written, transparent, and explicit project goals, timelines, shared language, roles, responsibilities, and funding agreements. A CBO interviewee discussed the importance of transparency, *"There has to be transparency and accountability – and that means in the strategy of decision-making, and in the resources… [If] a researcher from an academic institution is coming to your community and is trying to invite you to be part of the research project, but they will never show you the budget. That's a sign, maybe some reason to say no thank you." (CBO).*
D. TPH groups must be willing to share (or relinquish) power with CBOs through a formalized, inclusive decision-making process. A TPH interviewee emphasized this point by saying, *"There can be tension when you cede control to community groups that you have to be okay if what comes out of that process doesn't completely align with your*

*agenda or your strategies… You can't say we want community driven processes and then say, 'Like, oh, but only if it's the outcomes we agree with.'" (TPH).*

E. Have a partnership facilitator "at the table," especially for new partnerships, who understands both the CBOs' and TPH groups' perspectives and language.

Interviewees' recommendations for ensuring an equitable funding landscape:

F. Ensure affected communities, and CBOs that represent them, provide input on the development of research and funding agendas, especially for projects that may impact their community.

G. Develop 'calls for proposals' in which CBOs are the project leads with authority to subcontract for technical expertise if needed. One interviewee described this as, "*there are some funders that require the funding to go to the community and the researcher becomes like a consultant on it. I like that model too. That is for doing research, also for implementing programs… the organization would be the applicant and co-PI." (CBO).*

H. Provide funding that supports long-term community efforts and core capacity building of CBOs rather than short-term projects.

I. Implement a tiered approach to funding that recognizes the varying capacities of CBOs to strengthen lower-capacity organizations for long-term growth of the CBO field.

J. On projects and initiatives that require technical expertise (e.g., statistical support), prioritize funding to technical expert groups from the affected community to support local capacity building. A CBO interviewee explained this as, *"We historically have been undercut by external folks and their closer connection to funders allows them to get funded… And you know it is detrimental to local groups because there's local groups that*

*really do have the skill and capacity to do that… So I feel like that is really negative and places small organizations in subordinate roles." (CBO).*

## DISCUSSION

Interviewees discussed power dynamics in CBO-TPH partnerships and issues that resulted. CBOs working to promote health equity often represent communities that have been marginalized by some of the same institutions that TPH groups represent (e.g., governmental institutions).[7] There can be inherent distrust among CBOs towards TPH groups due to histories of oppression and exploitation.[8] These historically rooted perspectives vary between CBOs and TPH groups and can lead to differing ways in which these two groups approach the work of advancing health equity.[7] Interviewees also pointed out these inherent differences, primarily in cultural humility and language use, and ways in which the groups approached weighing various forms of knowledge.

Studies that have investigated partnerships between researchers and marginalized communities (e.g., community-based participatory research) advocate for a similar set of principles on navigating trust issues and developing strong partnerships.[8-11] Their guidance includes: partnerships acknowledging institutional histories and power imbalances; researchers needing to understand the community and historical context of the issue being addressed; sharing decision-making, language, and ownership to reduce power imbalances; encouraging community-ownership by holding partnership activities in the community; establishing group norms by being upfront and transparent about expectations, processes, roles, and goals; and finally, researchers being willing to not only share power, but also to be challenged and be vulnerable.[8-11] Such

relationship building can take a considerable amount of upfront time and funding to support these activities.[8] Interviewees in the current study identified similar recommendations for establishing CBO-TPH partnerships and building trust.

One of the primary advantages CBOs have in terms of addressing health disparities is that they can be experts on local needs, resources, and strengths, which is crucial knowledge for tailoring interventions.[2] However, large national public health entities and foundations dominate funding and may have ideological differences compared to CBOs.[7] CBOs often must adopt a "corporate model" that promotes competitive positioning in the field in relation to available funding streams.[12] Therefore, CBOs are in danger of succumbing to mission creep. If the public health field is interested in addressing health equity, then funding should follow the lead of CBOs who represent the needs of vulnerable populations. However, CBOs currently have limited input into TPH funding and research agendas.[13, 14] Interviewees in this study recommended increased involvement of CBOs in developing funding agendas and mechanisms to ensure available funding meets their needs (e.g., more CBO-led grants, longer-term funding, and local capacity building). Echoing these interviewees' perspectives, an evidence review commissioned by the World Health Organization outlined best practices for setting research agendas and similarly advocated for including perspectives of diverse stakeholders in information collection and decision-making processes.[15]

This study has limitations and strengths. Interviewees were current or former partners of Praxis, and may have differing perspectives on CBO-TPH partnerships compared to others. Also, while understanding CBO-TPH partnerships was a major aspect of the overall project, it was not the

sole focus of the interviews. Therefore, themes presented in this study could have benefitted from additional exploration to elucidate more detail and examples. Further, CBOs were not involved in creating the interview guide or study objectives. Such a process could have led to richer data and identification of themes that were not elucidated in this analysis. A major strength of this study is the inclusion of diverse perspectives, including CBOs, TPH groups, and Praxis representatives, as well as demographic diversity of our sample.

### *Conclusions*

Equitable partnerships between CBOs and TPH groups are possible and can begin with personal relationship building, addressing power dynamics, and inclusive research and funding agenda-setting processes. TPH groups partnering with CBOs can follow the practical guidance presented in this study and others to promote strong, mutually beneficial partnerships.

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