

**Re-Envisioning Community-Led Public Health Through a Case Study of Chicago's  
Response**

BY

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THESIS

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This dissertation is dedicated to my family, who have supported and encouraged me throughout my journey to this point in my life.

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AG

## TABLE OF CONTENTS

<u>CHAPTER</u>	<u>PAGE</u>
1. INTRODUCTION .....	1
1.1 The Value of Cross-Sector Collaboration .....	2
1.2 The Public Health Political Landscape .....	3
1.2.1 Evolving Conceptualization of the Public Health System and Function .....	4
1.2.2 A Transition from Public Health Governing to Collaborative Governance .....	5
1.3 Cross-Sector Collaboration in Practice: A Contradictory Approach .....	6
1.4 Current Study .....	7
1.4.1 Specific Aims .....	8
1.4.2 Case Study Context .....	8
1.4.3 Role of the Researcher .....	9
1.4.4 Community Engagement.....	11
Cited Literature .....	13
2. EXPLORING NON-PARTICIPATION OF COMMUNITY-BASED ORGANIZATIONS IN A CITY-FUNDED PUBLIC HEALTH EMERGENCY INITIATIVE .....	18
2.1 Introduction.....	18
2.1.2 Reasons for CBO Non-Participation in Public Health .....	19
2.2 Methods, Approach, and Analysis.....	23
2.2.1 Community Engagement.....	24
2.2.2 Sampling and Recruitment.....	25
2.2.3 Key Informant Interviews.....	25
2.2.4 Pre-Interview Activity.....	26
2.2.5 Field Notes.....	27
2.2.6 Analysis .....	28
2.3 Results .....	29
2.3.1 “Outside of Our Scope of Work” .....	30
2.3.2 Not Responsive to Community Needs.....	31
2.3.3 Technical and Administrative Concerns .....	32
2.3.4 Cross-Cutting Insights.....	33
2.3.4.1 The Community Comes First .....	33
2.3.4.2 Doubts about Long-Term Impact .....	35
2.4 Discussion .....	36
2.4.1 Limitations.....	38
2.4.2 Conclusions .....	39
Cited Literature .....	40
3. WHO PARTICIPATES IN GOVERNMENT SPONSORED PUBLIC HEALTH: A CASE STUDY DOCUMENT ANALYSIS .....	44
3.1 Background .....	44
3.2 Methods.....	46
3.2.1 Design .....	46
3.2.2 Context .....	46
3.2.3 Data Collection.....	47
3.2.3.1 990 Forms .....	47

## TABLE OF CONTENTS (continued)

<u>CHAPTER</u>	<u>PAGE</u>
3.2.3.2 CBO Websites .....	49
3.2.4 Inclusion Criteria .....	49
3.2.5 Analysis .....	50
3.2.6 Study Advisory Board.....	50
3.3 Results .....	51
3.3.1 Organizational Nature and Focus.....	51
3.3.2 Workforce and Organizational Capacity .....	53
3.3.3 Partnerships.....	56
3.4 Discussion and Conclusions .....	57
3.4.1 Limitations.....	60
3.4.2 Conclusion .....	60
Cited Literature .....	62
 4. A PICTURE OF COMMUNITY-LED PUBLIC HEALTH: INSIGHTS FROM COMMUNITY- BASED ORGANIZATION LEADERS .....	 67
4.1 Introduction.....	67
4.2 Methods, Approach, and Analysis.....	70
4.2.1 Community Engagement.....	71
4.2.1 Sampling and Recruitment.....	72
4.2.3 Key Informant Interviews.....	72
4.2.4 Field Notes.....	73
4.2.5 Analysis .....	74
4.2.6 Description of Dataset.....	75
4.3 Results .....	75
4.3.1 Giving up Control .....	76
4.3.2 Created Spaces .....	77
4.3.3 Systems Demonstrating Trust in CBOs .....	78
4.4 Discussion and Conclusions .....	80
4.4.1 Limitations and Conclusions.....	82
Cited Literature .....	84
 5. CONCLUSIONS.....	 89
5.1 Inviting All CBOs into Public Health .....	89
5.2 Moving Towards Transformative System Change.....	91
5.2.1 Implementing Trust-Based Collaboration .....	93
5.3 Redefining Public Health Investment .....	94
5.4 Advisory Board Reflections.....	96
5.5 Limitations and Implications for Practice and Research .....	97
Cited Literature .....	99
VITA.....	104

## LIST OF TABLES

<u>TABLE</u>	<u>PAGE</u>
I. ESSENTIAL PUBLIC HEALTH SERVICE REVISIONS.....	5
II. RESEARCH STUDY METHODS OVERVIEW .....	10
III. INTERVIEWEE CHARACTERISTICS.....	30
IV. DATA COLLECTION VARIABLES.....	48
V. PROGRAM AREAS BY ORGANIZATION TYPE N (%) .....	53
VI. N (%) APPLICANT ORGANIZATION CHARACTERISTICS .....	55

## LIST OF FIGURES

<u>FIGURE</u>	<u>PAGE</u>
1. Conceptual framework .....	20
2. CONSORT diagram .....	49

## **LIST OF ABBREVIATIONS**

CBO	Community-Based Organization
EPHS	Essential Public Health Services
LHD	Local Health Department
RFP	Request for Proposal
NFP	Not for Profit



## **SUMMARY**

In efforts to increase community leadership and equity in public health, local health departments (LHDs) partner with community-based organizations (CBOs). This is because CBOs are thought to be well-positioned to participate in community-led public health practice due to their familiarity with the community and trust with the community that they may have built over time due to their embeddedness in the community. To identify how LHDs can expand opportunity for community-led public health, it is important to know what kinds of CBOs participate in public health, why some do not, and what kind of transformation is needed to create a public health system that equitably includes CBOs. This mixed methods study provides insights on these topics using a document analysis and interviews with CBO managers and executives. The study was conducted in a case study context with organizations that did or did not apply to the Chicago COVID-19 Contact Tracing Corps in 2020, funded by the Chicago Department of Public Health. This study had three aims: 1) To address the assumptions underlying CBO participation in LHD activity by examining the knowledge, attitudes and beliefs of CBO leadership who chose not to participate in the initiative; 2) to examine, characterize, and differentiate funded and unfunded applicants of a government funded public health initiative; and 3) to explicate what a community-led public health approach looks like in a Chicago. A mixed methods document analysis using CBO website information and tax forms identified the characteristics of CBOs that applied to the large publicly funded initiative and differentiated characteristics of those that did and did not get funded. Funded organizations tended to have a history of more government grants and of greater amounts, compared to non-funded organizations who had lower revenues and less revenue from grants and fundraising. Funded and non-funded organizations were not clearly differentiated by mission and program areas, and both groups had partnerships with governmental institutions and other CBOs—highlighting that

## **SUMMARY (CONTINUED)**

workforce, financial, organizational capacity may be the most important determining factors to a CBO getting funded, not necessarily the mission or programmatic alignment. Six interviews in-depth 90-minute interviews with CBO managers and leaders at small organizations described how they approach reading a request for proposal, why they chose not to apply to the initiative, and defined what a community-led approach looks like. The thematic analysis revealed that CBOs chose not to apply because the initiative was outside of their scope of work, it was not responsive to pressing community needs, and technical and administrative concerns.

Participants showed that they prioritized sustainably meeting the needs of the community rather than reacting to those needs with prevention and education. A secondary critical discourse analysis of the interview data provided insight underpinning their perspectives on power-sharing for community-led public health. Findings were the need for the LHD to give up control, allow for participatory spaces, and establish systems that demonstrate trust in the CBOs. These findings suggest that CBOs are theoretically equipped to lead public health efforts but there needs to be system transformation and wise investment that supports an infrastructure for community-led public health. This would require both LHDs building initiatives that appeal to a wide variety of innovative CBOs, as well as organizations being more eager to explore what it means for them to be a part of the public health system. By giving power to CBOs to lead public health work and creating spaces and structures for that work to happen, the public health system can better address health inequities.

## 1. INTRODUCTION

Increasing recognition of the social and structural determinants of health<sup>1–3</sup> has led to a call for approaches that address structural violence. Structural violence is any kind of violence exerted systematically, whether through institutions, ideologies, policies, or other codified practices that inevitably results in oppression and perpetuated inequities such as poverty, crime, trauma, lack of access to care, healthy food, or physical activity.<sup>3,4</sup> To this end, public health strives towards health equity—reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups are persistent and notable in many communities.<sup>5</sup> These social issues have drawn attention to the necessity for communities to be involved in public health decision-making.<sup>3,6,7</sup> Community ownership and control yields better outcomes and more sustainable efforts, and participatory processes allocates resources more efficiently for health equity.<sup>6,8,9</sup> These insights led to the development of the Public Health 3.0, a “renewed public health approach” and a framework that positions communities as essential in leading the charge to public health success.<sup>10</sup> This approach also calls for local health departments (LHDs) to take on the role as the chief health strategist, acting as coordinators of the public health system within communities.<sup>11–13</sup> Accordingly, now government leaders call for collaboration with communities to address issues in community health and development.<sup>10,14–16</sup>

A common avenue by which LHDs engage with communities is through community-based organizations (CBOs), which are broadly defined institutions controlled within a community, and they contribute to community capacity in a variety of ways. Examples include cultural organizations, communications organizations, faith-based organizations, and civic organizations that build individual assets in the community.<sup>17</sup> Because of their role in communities, CBOs are good partners for community health efforts because they can serve as

proxies for community voice.<sup>8,18</sup> In particular, LHDs partner with formalized organizations with not-for-profit (NFP) status. The public's trust in nonprofit organizations is deeper than that of the government,<sup>19</sup> so CBOs may be well positioned to work with communities. Working with CBOs can also increase public trust in the government and increase volunteerism.<sup>19</sup> In addition, engaging with community partners helps funders understand fundamental values and needs of the community.<sup>20</sup> This is essential to keep public health promotion and intervention relevant and culturally appropriate.

### **1.1 The Value of Cross-Sector Collaboration**

A distinguishing feature of collaborative partnerships for community health is broad community engagement.<sup>21</sup> Community engagement and collaboration occur on a spectrum<sup>13,22–25</sup> and are strategic, depending on shared goals and purpose.<sup>22,23,25,26</sup> Collaboration between LHDs and CBOs occurs across a continuum community-informed to community-led,<sup>13,22–25</sup> with the ideal being a community-owned approach where local visions for change are defined and implemented by the community, who are in control of all resources, parameters, and decisions.<sup>27</sup> Forms of community engagement include participatory mechanisms like town halls and feedback sessions, participatory budgeting, or public surveys.<sup>28</sup> Public agencies also designate some staff roles to include community engagement and allocating new roles to champion participation.<sup>28</sup>

It is well accepted that collaboration across sectors (e.g. public, private, not-for-profit) increases the capacity of the public health system to advance health equity.<sup>29–32</sup> There are several different outcomes of collaboration and community engagement for which it has utilitarian and social justice values.<sup>33</sup> First, there is the utilitarian perspective of collaboration having public value.<sup>24,33,34</sup> Collaborative partnerships can expand opportunities for physical activity, promote health, increase access to healthcare and healthy food, provide high-quality

education, and increase evidence for decision-makers and community development initiatives.<sup>30</sup> Collaborations result in improvements in population level outcomes and community-wide changes in health behavior such as tobacco use or eating behaviors.<sup>21,30,35</sup> Collaboration can also result in long term system changes,<sup>8</sup> like developing and/or implementing new public health priorities, policies or practices, establishing or expanding service or program access and availability, improving evaluation, securing financial and/or technical resources, and adopting new community-wide interventions and built environment changes such as development of parks or trails.<sup>21,32,36</sup> Collaboration also increases overall health system capacity because it provides mutual benefit for the partners,<sup>24,29,37</sup> increases cultural competency and linguistic diversity of staff,<sup>13</sup> reduces competition between organizations,<sup>32</sup> and creates links to community networks and community resources.<sup>32,36,37</sup> Because of these many benefits of collaboration, many emphasize collaboration as important to meeting health equity goals.

Collaboration can also be valued from an empowerment or social justice perspective<sup>33,34</sup> Collaboration is a tool for empowerment, where people are given power to participate, influence, and hold institutions accountable. In this view, participation is valued as an avenue of civic participation and democracy.<sup>34,38</sup> Calls for participation, community engagement, and partnership should be rooted in a recognition that impetus for change exists beyond the government. An empowerment model requires that power is shared with the community, the health needs are identified by the community, and they lead action.<sup>9,33,36,39</sup> When collaboration is used for social justice, it also allows for shared responsibility for community health<sup>36</sup> and is demonstrated in citizen satisfaction in the government.<sup>32</sup>

## **1.2 The Public Health Political Landscape**

When discussing participation in the public health system, it is essential to consider to context in which the collaboration will occur.<sup>30</sup> Community participation is inherently political,

because true participation is a threat to those in power.<sup>34</sup> It is important to contextualize the current political landscape because with political orientations are attached with specific structures, processes, outputs, and outcomes.<sup>40</sup>

### **1.2.1 Evolving Conceptualization of the Public Health System and Function**

There has been dramatic change in the public health system over the past few decades.<sup>12,16,41,42</sup> The shift in public health can be seen by examining the revisions to the ten essential public health services from 1994 to the recent 2020 revision (Table I).<sup>42</sup> The ten essential public health services (EPHS) framework was created in 1994 in order to create shared language and understanding about the roles and responsibilities of the public health system.<sup>42</sup> Since its conceptualization, the EPHS framework has been used to identify national public health performance standards, develop accreditation criteria for the Public Health Accreditation Board (for LHDs) and the Council on Education for Public Health (programs and schools), and guide local health department's structure, policies, and approaches.<sup>16</sup> With the 2020 revision comes emphasis on public health's responsibility to protect and promote the health of people in all communities, with equity situated at the center of the essential public health services. The prominent placement of equity within the essential public health services and the revisions to the service descriptions themselves reflect the wide recognition of structural violence<sup>3,43</sup> as a root cause of health inequities and a dependence on collaboration in order to achieve the EPHS. The revision acknowledges that the public health system is made up of governmental bodies, including politicians, city, county, state, and federal departments of health, public health, planning, education, transportation, human and social services- as well as non-governmental organizations such as community-based organizations, civic engagement groups, employers, faith-based organizations, etc. By extension, the public health workforce includes healthcare providers, researchers, scientists, social workers, educators, and more. Changes to the EPHS

<b>Table I. ESSENTIAL PUBLIC HEALTH SERVICE REVISIONS</b>	
<b>1994 EPHS</b>	<b>2020 EPHS</b>
<b>Assessment</b>	
Monitor health	Assess and monitor population health
Diagnose & Investigate	Investigate, diagnose, and address health hazards and root causes
<b>Policy Development</b>	
Inform, Educate, Empower	Communicate effectively to inform and educate
Mobilize Community Partnerships	Strengthen, support, and mobilize communities and partnerships
Develop Policies	Create, champion, and implement policies, plans, and laws
Enforce Laws	Utilize legal and regulatory actions
<b>Assurance</b>	
Link to/provide care	Enable equitable access
Assure competent workforce	Build a diverse and skilled workforce
Evaluate	improve and innovate through evaluation, research, and quality improvement
Research	Build and maintain a strong organizational infrastructure for public health

are meaningful because they are built into the definition of what LHDs do and Healthy People Initiatives managed by the Office of Disease Prevention and Health Promotion at the U.S. Department of Health and Human Services. The EPHS also spurred the restructuring of LHDs and were incorporated into public health laws and continue to guide budgetary decisions.<sup>16</sup>

### **1.2.2 A Transition from Public Health Governing to Collaborative Governance**

Since the turn of the century, the role of the state has shifted from governing through direct forms of control to collaborative governance, which brings public and private actors together using particular processes like forums, to establish laws and rules for the provision of goods.<sup>44</sup> Collaborative governance designates a specific role of state actors like LHDs and non-state actors like community-based organizations, and all these stakeholders should work together using two-way communication and shared responsibility for outcomes. Some suggest

this new form of governance does not replace the old one, but rather uncomfortably interacts with it.<sup>28</sup>

With the shift to collaborative governance, collaboration is more common, as is a government institution contracting out a service that was previously conceptualized as their own responsibility. Collaborative governance gives community institutions a role because they are seen to have capacity for social capital and community cohesion; improve service delivery through having a greater voice in planning and monitoring; meet local needs through delivering their own services; and address concerns about the democratic deficit through re-engaging citizens with government institutions.<sup>45</sup> As a result, there is more emphasis on community involvement in decision-making.<sup>38,46</sup> Understanding of the broader political landscape is a useful lens to examine the changes within the public health system over the past several decades and LHD's overall approach to collaboration with CBOs.

### **1.3 Cross-Sector Collaboration in Practice: A Contradictory Approach**

While LHDs recognize collaboration's utilitarian and social justice value, the processes of participation, representation, and decision-making procedures are drawn from the traditions of bureaucracy, rather than the true values of collaboration.<sup>47</sup> First, collaboration is commonly treated as an outcome rather than as a process. Because of its utilitarian value, collaboration is assumed to be the best approach to solving an issue that impacts the community<sup>24,48</sup> and now, governments and foundations insist that grantees collaborate with little evidence to justify why the collaboration is needed.<sup>24</sup> In fact, a neoliberal approach<sup>4,47,49</sup> puts greater emphasis on collaboration as beneficial due to its resource-saving or efficacy outcomes in efforts to save time and money, rather than emphasizing collaboration for its health justice potential. The result is an unstable public health infrastructure, marked by an aging workforce, challenges in disease surveillance, and gaps in disaster preparedness.<sup>47,50–53</sup> Inevitably, there is a question if this



enthusiasm for collaborating for public health is the result of a growing value for community voice and agency, or if these processes are a method for governments to outsource services, set a political stage, or hide community advocacy.<sup>9,33,54–56</sup> Words like “community”, “partnership”, and “community engagement” have become buzzwords<sup>28,48,55,57</sup> and scholars question community engagement as a spray-on solution<sup>58</sup>, a cult<sup>48</sup>, a holy grail<sup>59</sup>, a fad<sup>57</sup>, and opportunism.<sup>55</sup>

Expanding the community’s role draws attention to the tension between the traditional bureaucratic and hierarchical structures of government and the mandate to create more horizontal interactions with diverse organizations outside of government.<sup>38</sup> Governing bodies must share power with the community in order for lasting change to occur,<sup>28,38,48</sup> but bureaucratic structures result in limited power sharing in spaces with the community is invited.<sup>45</sup> LHDs and other governing bodies structure opportunities top-down,<sup>47</sup> following the norms of their own bureaucratic system that are in direct conflict with values of community engagement, power-sharing, and genuine participation. In addition, these efforts are dominated by health departments and hospital executives as the designated accountable body in partnerships.<sup>54,60</sup> This top-down administrative structure makes it so other partners have limited flexibility and are expected to comply,<sup>38</sup> since the department of health is responsible for financial management of resources and performance.

#### **1.4 Current Study**

Despite the contradictory characteristics of collaboration across the public health system, community-based organizations still apply and agree to participate in “collaborative”, local governmental public health initiatives. The nonprofit sector includes diverse fields including healthcare, education, or other social services and they serve various roles as service providers, influences and shapes the policy process, and governs communities.<sup>15,61</sup> To address

health equity, all types of CBOs should be welcomed to participate in public health. As collaboration has become a common approach within public agencies including LHDs, it is important to understand why some choose not to apply, what types of CBOs participate in collaborative opportunities, and how public health initiatives can be structured for reciprocal collaboration with CBOs. To address these areas of inquiry, I used a case study approach, conducted a community-informed, mixed methods study examining CBOs that applied to a city-funded public health initiative and interviewing CBO leadership who did not apply for the initiative.

#### **1.4.1 Specific Aims**

This study aims to address research gaps related to government-funded cross-sector collaboration for public health. To better understand contradictions and conditions of collaborative participation, I have conducted a case study with three aims:

1. *To address the assumptions underlying CBO participation in LHD activity by examining the knowledge, attitudes and beliefs of CBO leadership who chose not to participate in the initiative*
2. *To examine, characterize, and differentiate funded and unfunded applicants of a government funded public health initiative*
3. *To explicate what a community-led public health approach would look like.*

To address the above aims, I conducted a sequential mixed and multiple methods study using the Chicago COVID-19 Contact Tracing Corps (aka ChiTracing) initiative as a case study (see Table II).

#### **1.4.2 Case Study Context**

As I asked these research questions during a pandemic, a case presented itself as an optional context to conduct this research, given the intense need for community engagement in rapid

public health response. To address the disproportionate impact of COVID-19 on Black and Hispanic residents during the COVID-19 pandemic, the Chicago Department of Public Health created a contact tracing initiative that included hiring community members to conduct contract tracing and resource sharing. Contact tracing is an approach used to slow to spread of communicable diseases, in this case notifying individuals that they have been exposed to someone with a confirmed case of COVID-19, providing testing and quarantine guidance, and linking them to resources. The City allocated 24.6 million dollars directly to community-based organizations (up to \$896,100 per organization) and the remainder of funds allocated to resource coordination, evaluation, and technical assistance. CBOs were invited to apply during two rounds of requests for proposals (RFPs) in July and August 2020. Eligible CBO grantees were those that were non-clinical, not-for profit organizations that serve specific populations or community areas; are in accordance with federal, state, and local law, and eligible to do business with local government entities, and possess competence and capacity to accomplish the scope of work. The RFP communicated three overarching goals of the initiative: 1) hire a community-based workforce to immediately help prevent and mitigate community transmission of COVID-19; 2) provide earn-as-you-learn opportunities for the community-based workforce to promote career pathways and long-term sustainable income growth; and 3) invest in community areas experiencing economic hardship to promote economic recovery.<sup>65</sup> Applications were evaluated based on the following criteria: location in and service to high economic hardship community areas (20 points), respondent qualifications (40 points), program design (20 points), and fiscal proposal (20 points). The initiative began in September 2020 and was ultimately extended and expected to end in June 2022.

#### **1.4.3 Role of the Researcher**

I have been involved in the initiative as a research assistant for the UIC School of Pub

<b>Table II. RESEARCH STUDY METHODS OVERVIEW</b>				
<b>Aim</b>	<b>Question</b>	<b>Sub-questions</b>	<b>Data Sources</b>	<b>Analytic Methodologies</b>
<i>To address the assumptions underlying CBO participation in LHD activity by examining the knowledge, attitudes and beliefs of CBO leadership who chose not to participate</i>	<i>what informs CBO's decision to engage in government-led initiative?</i>	<ul style="list-style-type: none"> <li>- What do CBO leaders think about or look for when they read a public health infrastructure RFP?</li> <li>- What is the role of context, congruence, and capacity?</li> <li>- What role does money play?</li> <li>- What are perceived advantages and risks?</li> </ul>	<ul style="list-style-type: none"> <li>- Key-informant annotated RFP</li> <li>- Key-informant interviews</li> <li>- Field Notes</li> </ul>	<ul style="list-style-type: none"> <li>- Reflexive Thematic analysis</li> </ul>
<i>To examine, characterize, and differentiate funded and unfunded applicants</i>	<i>what are the characteristics of CBOs who participate in an LHD-funded initiative during a pandemic?</i>	<ul style="list-style-type: none"> <li>- How are grantees differentiated from non-funded applicants in terms of organizational nature and focus, workforce, and organizational capacity, connectedness to other CBOs, and readiness?</li> <li>- is there a "certain kind" of CBOs that are funded?</li> </ul>	<ul style="list-style-type: none"> <li>- CBO websites</li> <li>- CBO federal tax forms</li> </ul>	<ul style="list-style-type: none"> <li>- Document analysis</li> <li>- Summative content analysis</li> <li>- General descriptive statistics (ranges, frequencies, basic descriptive statistics)</li> </ul>
<i>To explicate what a community-led public health approach looks like</i>	<i>what does a community-led approach look like?</i>	<ul style="list-style-type: none"> <li>- How is it structured?</li> <li>- What spaces of participation are there?</li> </ul>	<ul style="list-style-type: none"> <li>- Key informant interview transcripts</li> <li>- Field Notes</li> </ul>	<ul style="list-style-type: none"> <li>- Inductive discourse analysis of secondary data</li> </ul>

Health, I approach this project with an insider/outsider perspective, recognizing that I as the researcher am an instrument of research.<sup>63,64</sup> My insider perspective comes from my role in the project. In August 2020, I reviewed and scored 5 CBO applications during the round 2 funding, and since then I have primarily been involved with CBO support initiatives throughout the project, throughout the past two years of funding. I provided feedback to funded CBOs in a limited capacity, taking notes, and preparing materials for presentations from our team. The regular meetings I attended throughout the initiative includes weekly meetings with CBOs during their check in meetings, attending and planning activities at the bi-monthly community of practice that is for CBO leadership, and attendance at other meetings with CBO stakeholders who act as consultants for the initiative. Throughout my role, I have maintained field notes in a separate journal to record reactions, thoughts, and observations from the initiative, specifically regarding the collaboration between groups. These field notes became a body of work that initially guided the development of the research questions and study design, and later were used as a data source for the study.

#### **1.4.4 Community Engagement**

In this study, I centered the expertise of stakeholders who share a similar social context at every stage of the research.<sup>13</sup> The study was informed by a 3-member advisory board that was convened at the start of the study. The advisory board addresses potential biases such as assumptions and preconceived ideas that come with people being studied but not those doing the studying.<sup>65</sup> Advisory board members were intentionally recruited to bring diverse experiences as non-profit executives, board members, and technical assistance providers who each hold at least a master's in public health degree. Advisory members brought decades of experience in nonprofit management, evaluation, technical assistance, as well as personal

experience as Black, Hispanic, and white long-time Chicago residents with varied experiences with structural violence. The advisory board met three times and provided feedback throughout different stages of the study. During the first meeting, advisory board members provided overall feedback on the research questions and overall study design. In addition, advisory board members provided feedback on the participant recruitment flyer to exclude jargon and use words that were familiar to the target audience. Advisory board members helped refine the data collection as well. They provided ideas for data collection approaches for the document review in this study, feedback on the participant annotation exercise, and suggested probes for the interview that would result in more specific answers to the research questions. Lastly, members also were engaged for member checking, which is explained in the analysis section for each paper. Members of this advisory board were compensated for their time, at \$50 per hour.

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## **2. EXPLORING NON-PARTICIPATION OF COMMUNITY-BASED ORGANIZATIONS IN A CITY-FUNDED PUBLIC HEALTH EMERGENCY INITIATIVE**

### **2.1 Introduction**

The public health system is made up of all public, private, and voluntary entities that contribute to the delivery of public health services.<sup>1</sup> This includes governmental bodies- including politicians, city, county, state, and federal departments of health, public health, planning, education, transportation, human and social services- as well as non-governmental entities such as community-based organizations, civic engagement groups, employers, educators, scientists, social workers, etc. Although there is recognition of the various actors in the public health system, there is an increasing value of non-healthcare institutions to deliver essential public health services.<sup>1-3</sup> This change is directly related to the acceptance of the social and structural determinants of health and the transition to Public Health 3.0.<sup>2</sup> Public Health 3.0 is a “renewed public health approach” and a framework that describes the growth of public health from the 19<sup>th</sup> century.<sup>2</sup> Traditionally, local health departments (LHDs) were one of many political institutions that had been established and maintained as a means of regulating health related matters in the state, city, or county. Now in this new framework, LHDs have the role of the chief health strategist, linking community-based organizations (CBOs) across various sectors to impact public health.<sup>2,4</sup>

As evidenced in the Public Health 3.0 vision and mission, decision-makers view the community as the unit of identify and emphasize that community involvement in decision-making can improve service delivery by allowing community members to have a voice in planning, monitoring, and delivering their own services.<sup>5-7</sup> The emphasis on community participation is seen through a plethora of requests for proposals (RFPs) with popular words like “partnership”, “collaboration”, “capacity building” and “local involvement” in policy practices and

development.<sup>8</sup> As a result of this move to collaborative governance, there are now institutional mechanisms that shape the form and process of participation that converge with the literature on cross-sector collaboration. Structures of participatory engagement include the creation of deliberative forums alongside initiatives to draw community groups into partnership with public sector organizations,<sup>8,9</sup> participatory budgeting, or public surveys.<sup>8</sup> Public agencies also designate some staff roles to include community engagement or allocating new roles to champion participation.<sup>8</sup>

While this shift towards participatory public health sounds positive, there are also negative aspects of it. The shift towards collaborative governance is marked by re-centralization, which is transferring responsibility downwards outside of the agency or outside the state by contracting out a service and constructing governmental decisions and outcomes as a shared responsibility.<sup>7,9</sup> The trade-off of this approach is that organizations inevitably become accountable to the government, rather than their original, intended service population of community residents, mission and goals. This can result in internal changes at the organization, including mission drift<sup>10</sup> and isomorphism,<sup>11</sup> where the organization takes on more characteristics of the government. So while governments call for participation from CBOs, not all organizations are willing and able to partner with LHDs and choose not to participate for a variety of reasons.

### **2.1.2 Reasons for CBO Non-Participation in Public Health**

There are three primary reasons that influence the decision for CBOs to participate in LHD sponsored initiatives: context, congruence, and organizational readiness.<sup>12–21</sup> **Error! Reference source not found.** depicts the conceptual model visualizing the reasons why a CBO may not choose to participate in a public health initiative.

**FIGURE 1. Conceptual framework**

A first reason CBOs may not participate in government funded public health is due to environmental and contextual factors in the CBO's community like citizen participation, community leadership, resources, and social and interorganizational networks can influence a CBO's ability or interest in participating.<sup>12,13</sup> In addition, CBO leaders may not agree with collaborative governance and believe that public services should be the sole responsibility of the state, not community organizations. Even when no apparent strings are attached, conflicts between a CBO and the financial sponsor (a local health department, for example), can raise difficult questions.<sup>22</sup> For example, an organization may have reservations accepting money from a city government that heavily invests in policing rather than mental health services, especially if that organization serves a community that is overpoliced and has experienced negative consequences of decreased mental health funding.

Context can also relate to how the opportunity will impact the organizations long-term.<sup>15</sup> Autonomy is an important factor in collaborations, and CBOs may not want to participate if they think their identities could be at stake<sup>14,15</sup> The process of collaborating with state actors can have negative consequences like “professionalizing” the community<sup>7</sup>, making community members strangers in their own community, or making the community distrustful of leaders,<sup>22,23</sup> or the organization function as an extension of the state, serving functions to audit, and legitimize activities like self-surveillance.<sup>7</sup> There is also a concern that working with government can shift ways of knowing and doing and that as communities shift into a relationship with bureaucratic organizations, they begin to adopt a bureaucratic way of doing things, a phenomena known as isomorphism.<sup>6,11,24,25</sup>

Another reason why CBOs might not participate is due to the congruence of the opportunity with their mission and existing programs. Research has found that organizations did not participate in collaborative initiatives because of divergence concerning the 1) objectives of the project and the organizational mandate; 2) the project’s focus on heart health vs. a broader focus, which could be seen as too narrow, and 3) project’s risk reduction strategy. Some organizations may not want to participate due to the geographic or population scope, if that does not correspond with the scale in which the organization is working.<sup>18</sup> For example, an organization that is a neighborhood association and primarily only works in that neighborhood may be less interested in engaging in a state-wide initiative. In addition, organizations may choose not to participate in an initiative because they do not perceive or interpret the initiative’s concerns as relevant to the needs of the organization or the community they represent. Similarly, an organization could agree on a mission or goal, but not the approach.<sup>19,26,27</sup>

A final reason why an organization may not apply is due to capacity and readiness. Organizational capacity can include human, physical, and knowledge resources, as well as the

processes that are used to transform resources into services.<sup>13</sup> Organizational readiness for public health might be having an organizational mandate with emphasis on health promotion, having staff or volunteers experienced in health promotion, having funds for health promotion, staff tasks that involve health promotion-related activities, etc.<sup>18</sup> Lastly, cross-sector collaboration occurs within a system and does not start with the individual partners themselves. In order for cross-sector collaboration to occur, there must be collaborative capacity from all actors involved.<sup>9,28,29</sup>

The existing literature shows that governments have many assumptions attached to their approach to partner with CBOs, and it is unclear how these assumptions are received by CBOs. One study found that there were three assumptions that underpinned an organizational members' initial interest in a project. First, that participation would be a reasonable amount of work and that the organization had time to participate, second that the benefits of the project would outweigh potential disadvantages, and third that involvement in the project would allow the organizations to fulfill their own expectations.<sup>18</sup> In another study, researchers surveyed 385 nonprofit organizations and 163 chief administrative officers in Georgia to examine the relationship between local governments and nonprofit organizations when they jointly plan or deliver services.<sup>25</sup> The majority of respondents said that benefits of cross sector collaboration were jointly addressing problems, improving community access to service, improving community relationships, and promoting shared goals. They found that reasons they did not want to engage were related to the capacity, mainly staff time to manage a partnership; the quality of relationships with the government; and the competition to compete with other organizations.

The COVID-19 pandemic has highlighted the urgency and importance of LHDs working across sectors for health equity –with businesses, schools, healthcare organizations, and community-based organizations. With the existing literature on why CBOs do and do not



collaborate for government public health activities, there remains many questions about the decision-making process that CBO leaders engage in when they decide not to participate. It is unknown which of factors are most important in determining participating in LHD-sponsored collaborative grants, and to what extent CBO concerns are addressed by RFPs written by LHDs. Existing frameworks<sup>9,21,26,29–33</sup> are helpful for understanding conditions for collaboration or predictors of successful collaborations, but not necessarily the decision-making process of CBO leadership in regard to whether or not to participate in an opportunity for a collaboration with a governing institution. It is important to understand how these decisions are informed to maximize participation these stakeholders so that the public health system can be more impactful and communities can build capacity. This study uses mixed qualitative research to examine the knowledge, attitudes and beliefs of CBO leadership who chose not to participate in an LHD-funded public health initiative.

## **2.2 Methods, Approach, and Analysis**

This study uses a specific public health initiative from the city of Chicago as a case study. The initiative called for non-clinical not-for profit community-based organizations to rapidly hire, train, and manage at least 16 individuals that would make up Chicago's contact tracing corps. This initiative was communicated as one designed to invest in communities disproportionately impacted by COVID-19 while creating a public health workforce representative of the residents. The RFP was released twice, with the first round open July 16, 2020 to July 30, 2020 for organizations that were invited as previous partners of the managing organization, and the second round was open July 28, 2020 to August 17, 2020 for any eligible organizations. The anticipated contract commencement was September 2020 and organizations about be awarded about \$800-900,000 for the year-long contract. There was one technical

assistance webinar for each RFP, and prospective applicants were also told that funding may be renewed for an additional 12 months depending on the programmatic need.

Using a critical, social constructivist lens,<sup>34,35</sup> I employed a mixed methods research design to explore what informs a CBO's decision to engage in a government-led public health initiative. First, I conducted a series of face-to-face 90-minute semi-structured key informant interviews with leadership from CBOs that did not respond to the initiative's RFP. The goal of the key informant interviews was to understand knowledge, attitudes, and beliefs of CBO leadership along the domains of the context of the opportunity, congruence between the goals and values of their organizations, and their own organizations' capacity and readiness. Individual interviews are a useful method for exploring topics in depth and result in rich information about personal experiences and perspectives, especially for sensitive topics such as frustrations related to the public health system or lack of funding.<sup>36,37</sup> The use of individual interviews is also exemplified in health research<sup>36</sup> and governmental research.<sup>7,8</sup> In addition to the interviews, other data sources included pre-interview annotations of the RPH from research participants as well as researcher field notes.

### **2.2.1 Community Engagement**

In this study, I centered the expertise of stakeholders who share a similar social context at every stage of the research.<sup>26</sup> The study was informed by a 3-member advisory board that was convened at the start of the study. The advisory board addresses potential biases such as assumptions and preconceived ideas that come with people being studied but not those doing the studying.<sup>38</sup> Advisory board members were intentionally recruited to bring diverse experiences as non-profit executives, board members, and technical assistance providers who each hold at least a master's in public health degree. The advisory board met three times and provided feedback throughout different stages of the study. First, advisory board members

provided feedback on the recruitment flyer to exclude jargon and use words that were familiar to the target audience. In addition, advisory board members helped refine the participant annotation exercise instructions and suggested probes for the interview that would result in more specific answers to the research question. Lastly, members also were engaged for member checking, which is explained in the analysis section. Members of this advisory board were compensated for their time, at \$50 per hour.

### **2.2.2 Sampling and Recruitment**

Participants were recruited through a recruitment flyer was shared on listservs with funders, research networks, and through word-of-mouth referrals from the author and the advisory board members. Interested individuals were assessed for eligibility in the study via a brief survey distributed over email. Eligible participants were over 18 years old, employed at a not-for-profit, non-clinical community-based organization in the city that did not apply for the initiative; and had a position where they participated in decision-making related to applying for RFPs. After assessing eligibility and reviewing study information, interested individuals were enrolled for participation in the study and scheduled for an interview according to their availability.

### **2.2.3 Key Informant Interviews**

A semi-structured interview guide was created and was structured to cover the domains that influence a CBO's decision to apply: the context, the congruence, the organization's capacity and readiness. Participants were asked to describe their context, namely share information about organization, including their service population, programs and services, how they are funded, how they assess community needs, how they responded to the pandemic, and how they see their organization as part of the public health system. Participants were also asked about their process and history of responding to RFPs, namely governmental and public

health RFPs, as well as history of partnering with government entities for public health initiatives. Lastly, participants were asked about the initiative's RFP in terms of how they assess their CBO's ability to fulfill the scope of work, how it fits with their capacity, and other aspects of the RFP that discourage them from applying. The number of interviews was determined based on saturation.<sup>39</sup>

The interviews were conducted on zoom and audio and video recorded with automatic transcription. At the end of the interview, participants were asked to complete a brief demographic questionnaire that captured their gender, race/ethnicity, and highest level of education completed. These measures were used to capture these social identities of participants' responses to contextualize their responses and consider the diversity of the perspectives they bring.<sup>38</sup>

#### **2.2.4 Pre-Interview Activity**

To tailor the interview further, each participants' interview was informed by a pre-interview activity that acted as both an elicitation exercise and a second data collection method. All interviewees were asked to complete an exercise to annotate portions of the round 2 RFP for the initiative. Elicitation exercises can be considered part of a visual method and can be useful to establish meaning from participants' own created documents.<sup>40,41</sup> This exercise is designed to mimic a process that CBO leadership would potentially if they were considering whether to apply for the opportunity, which would encourage talking more specifically about the opportunity during the interview. To conduct the elicitation exercise, key informants were sent a word document with instructions, their participant ID number, and an excerpt of round 2 RFP with 1.5 spacing and a 2-inch right margin. The sections included in the excerpt were Section 1: Purpose, performance period, funding, schedule; Section 2: Background; Section 3: Eligible Respondents, and Section 4: Scope of Work. Participants were instructed to read the RFP

excerpt and annotate words or phrases that stand out to them as important, informs their thoughts on whether or not to apply, or raises questions or concerns. Guiding questions posed were “what key words do you look for that stand out in this RFP?”; “Are there parts you don’t understand or is confusing?”; and “what about this opportunity discourages you from applying?” The annotation was uploaded by participants to a secure Box folder and the annotations were reviewed prior to the interview. Information from the annotations provided insight for interview probes and ask interviewees to define terms in their own words. Participants who did not complete the annotation prior to the interview were still elicited by the interviewer reading sections of the RFP word-for-word or screensharing, whichever was preferred by the participant.

In exchange for their time spent annotating the RFP and participating in the interview, participants were compensated with a \$100 visa gift card, electronically delivered to their preferred email at the completion of the interview. The procedures of this study were approved by the University of Illinois Chicago Institutional Review Board.

### **2.2.5 Field Notes**

A third data source used in this study are researcher field notes.<sup>42–44</sup> I was involved in the initiative as a research assistant for the UIC School of Public Health, I approach this project with an insider/outsider perspective. This perspective is useful to research because prolonged engagement supports the credibility of the data.<sup>45</sup> reviewed and scored 5 CBO applications during the round 2 funding, and since then I have primarily been involved with CBO support initiatives throughout the project, providing feedback to funded CBOs in a limited capacity, taking notes, and preparing materials for presentations from our team. During the first year of the initiative, I attended weekly meetings with CBOs during their check in meetings, attending and planning activities at the regional community of practice that is for CBO leadership, and

attendance at other meetings with CBO stakeholders. As a participant-observer, I maintained field notes since August 2020.

Field notes include salient ideas that were noteworthy or interesting during meetings with project partners and events or meetings with funded organizations.<sup>43,44</sup> These salient ideas included both observational notes about what happened and what people communicated as well as theoretical notes, capturing themes and ideas raised during the field experience.<sup>42</sup> In particular, the field notes allowed me to reflect on my own participation in this project and document ongoing observations and potential biases.<sup>44</sup> The notes were organized chronologically in a single notebook and were later typed up and imported to the qualitative analysis software for reference.

### **2.2.6 Analysis**

Data were analyzed using Dedoose<sup>46</sup> using a reflexive thematic analysis approach, in which themes are conceptualized as meaning-based patterns and as the output of coding.<sup>47</sup> Thematic analysis lends itself to these research questions because of its goal of developing an understanding of patterned meaning and an interpretation of the data. The first step of reflexive thematic analysis was to be familiarized with the data, and the second step was generating codes for chunks of data. First, interview transcripts were coded both inductively and deductively. Interviews were first coded by structural coding, which applies a content-based or conceptual phrase representing a topic of inquiry related to a specific research question used to in the interview.<sup>48</sup> The second stage of coding was pattern coding, which pulls together materials into meaningful units of analysis.<sup>48</sup> The third, fourth, and fifth steps of thematic analysis are to construct, revise, and define the themes.<sup>47</sup>

The RFP annotations and field notes were used for triangulation. Triangulation is a process of cross-checking of data by use of different sources and methods that study the same

phenomenon.<sup>45</sup> In the case of this study, the interview themes were corroborated with the annotations and field notes to verify that the themes were reflected elsewhere in the initiative. Field notes and document annotations were incorporated into Dedoose as memos and later linked to themes as they were constructed and revised. In particular, triangulation was key in the steps of constructing, revising, and defining the themes. This method bolsters the overall credibility and authenticity of the findings from the interviews.<sup>45</sup>

Following the identification of themes, I conducted member checking with advisory board members. Member checking is taking ideas back to participants and/or people who share the same social context of the research for their confirmation and it supports the credibility and confirmability of findings by providing input from CBO leadership to guide the study's data collection, analysis, and interpretation.<sup>45,49</sup> This process can also serve to elaborate categories and inquire to what extent they fit participants' experience. Member checking is a commonly used technique that allows for improving and verifying analysis findings.<sup>45</sup>

### **2.3 Results**

Six, 90-minute semi-structured interviews were conducted to understand what informed community-based organizations' decision to not apply for the Contact Tracing Corps Initiative. Four of the six participants also completed the RFP annotations. The interviews were conducted in March and April 2022 with program directors and executive directors at community-based organizations within Chicago (see Table III. ). Although some participants were relatively new to their role (i.e. ID 1), they had decades of experience at other CBOs as both program staff and in leadership roles. Participants belonged to organizations that had programs in areas of civic engagement, advocacy, violence prevention, youth development, case management, and community resource centers. Organization types were small to mid-size, with organizations ranging from 3 to 50 full time staff members. Across the interview data, RFP annotations, and

fieldnotes, three primary themes emerged that inform why CBOs did not apply to the city-funded public health initiative: it was outside of organization's scope of work, it was not responsive to community needs, and technical and administrative concerns with the funding opportunity. In addition, two cross-cutting themes emerged: that the community comes first and that there were doubts about long-term impact.

<b>Table III. INTERVIEWEE CHARACTERISTICS<sup>a</sup></b>							
<b>ID</b>	<b>Role</b>	<b>Time in Role</b>	<b>Gender</b>	<b>Race/ Ethnicity</b>	<b>Highest Degree Earned</b>	<b>Organization Program Areas</b>	<b>Staff Size</b>
1	program director	2 months	Male	Latin X	High School	violence prevention and outreach	30
2	executive director	3 years	Female	Chinese American	Masters	civic engagement, advocacy, outreach	7
3	executive director and founder	9 years	Female	African American	Doctoral	youth development, community resource center, violence prevention	3
4	program director	2 years	Male	Mexican	Doctoral	social services and community organizing	50
5	executive director	15 years	Male	White	Bachelors	social services and community organizing	50
6	executive director	5.5 years	Female	White	Masters	community resource center	6
<sup>a</sup> ID 4 and 5 belong to the same organization. Demographic variables are self-reported. Organization program areas and staff size were extracted from interviews.							

### **2.3.1 “Outside of Our Scope of Work”**

First, participants talked about how the RFP did not describe the work that they do.

Interviewees said they are looking for grants that “drive [their] work” (ID 03). The RFP describes



the initiative as one where CBOs “serve as local employers” and said the initiative was about “investing in communities most impacted by health inequity.” But as participants read the RFP, they took away that the opportunity was workforce development initiative or a site of employment for a phone bank and perceived it as being closer to healthcare than to community health. Interviewees said “that’s not my area of expertise” (ID 03) and “we’re not in the business of contact tracing” (ID 04). One participant annotated “[if the city is] creating a health workforce, [why] can’t [eligible applicants] be a medical org?” (ID 05). With healthcare being outside of CBOs’ scope of work since they were organizations that primarily do programming and services for community residents, there was concern that contact tracers would not be sufficiently professionalized for the job, since organizations did not have content knowledge to train a healthcare workforce:

My understanding is contact tracers just have very specialized training, and often, bachelors if not graduate level degrees in public health, to train them for this type of work. [...] We were not looking to build up a contact tracing workforce. (ID 04)

Interviewees spoke of seeing the value of contract tracing work but called it “a stretch” as it related to their organizations’ mission and goals. Furthermore, participants recognized that creating a contact tracing workforce was a big ask of their organizations and saw that “the funding really doesn’t suffice in terms of the demand, the hands-on that’s gonna be required to roll it out” (ID 03).

### **2.3.2 Not Responsive to Community Needs**

A second major theme was that the initiative as described in the RFP did not address tangible needs of CBOs’ client base. At the start of the pandemic, CBOs saw people losing their jobs, losing family members, and struggling to pay their bills. A major concern, then, was how people could get immediate relief. One interviewee stated that the initiative “doesn’t kind of fit

within our typical model of being very client-led and responsive to client needs” (ID 06). In order for the initiative to be congruent with CBO’s dedication to being responsive to the community needs, interviewees suggested that the funding opportunity should include money to give to individuals or put towards relief resources:

You're supposed to then point [people] to the website or give them a brochure or give them a list of phone numbers that they should call and to take? That's not the way [our organization] operates. We were on the ground trying to deliver and being engaged with people around the material needs. [It wasn't feasible] adding the responsibility of being a contact tracer to that, without any additional resources or material supports to get people the resource that they need to stay at home. (ID 04)

More broadly, participants noted if the funder puts a boundary around the groups or areas that can be served by the funding, it could potentially limit the work the CBO could do. Providing insight into their CBOs’ experience with grants that do not meet community needs, participants spoke about how many grants are prescriptive about what services to provide and to whom:

[The funder is] gonna give us [money] through [a funnel] and [tell us,] ‘this is how you spend it.’ [It’s] like, chicken wings and fish don't solve everything for us. There's more stuff [...] Sometimes the teams are like saying, ‘can we do this?’, and I'd be like, ‘Not on this grant. We'll find it somewhere else.’ (ID 1)

### **2.3.3 Technical and Administrative Concerns**

Another theme was that there were technical and administrative concerns related to unanswered questions about the RFP. Participants were frustrated by the lack of detail in the scope of work, including how expectations would change over time and how contact tracers would be trained. One interviewee expressed concern around what new systems they would need to adopt and “how easy it is. What would it be for us to train our workers to work within that system?” (ID 02). There was also concern around unstated outcome metrics, as one participant asked, “what are metrics around healthcare and violence prevention?” Without these details, it was difficult for CBOs to evaluate if they could fulfill the scope of work.

In addition, there were concerns about organizational capacity to apply for the grant and fulfill the scope of work. The application window was less than a month, which participants thought was a quick turnaround and a challenge since there was only one advertised technical assistance session. Participants also voiced concern with the capacity to hire 16 people in less than a month when the contract started, and with the grant operating on a reimbursement structure. For 3 CBOs, this meant dramatically expanding staff size and it would be a challenge for these smaller organizations to pay wages using existing funds while they waited to be reimbursed. One interviewee suggested that “if the grant can be paid at the assigning of the agreement, or partially, that would be better than the reimbursement structure” (ID 02). This was also reflected in participant annotations, as one interviewee wrote “concern: do we have the cash on hand to float the build up of this level of staffing in a new program?”

#### **2.3.4 Cross-Cutting Insights**

Across the ideas of CBOs’ scope of work, community needs, and the technical issues, there were some cross-cutting insights, informed by field notes.

##### **2.3.4.1 The Community Comes First**

Interviewees repeatedly described their work as being grounded in the needs of the community. All of the organizations were founded with a core mission to address a specific, identified need in the community, and the trajectory of each organization is based on finding resources to meet those identified needs. Participants reflected that if they were to expand their organizational scope for the scope of work described in the RFP, it would impact their capacity to do other essential work:

We absolutely want to connect residents with people who are doing job training, but [...] putting a bunch of capacity towards that would have taken away from our ability to continue with our core mission. (ID 06)

In regard to engaging in public health, participants read the RFP through the lens of how it met the needs of the community, and by extension, fulfilled their CBOs' central mission. CBOs did not reject the notion of having a role in public health, but instead their responses drew attention to the question that perhaps public health leaders do not understand what the community needs. Although the participants represented CBOs that did not apply to the funding opportunity, these CBOs were resourceful in finding funds to meet the needs of the community during the pandemic. Participants spoke about their organizations' response to the pandemic, such as how they created and administered needs assessment surveys and outreach phone calls to identify the needs of current and previous clients. These organizations did not acquire specific funding to perform these services, but did so with their own reserve funding. Another participant organized resources among various organizations in their community, started a 24-hour COVID response phone line, and began a small business assistance program. Several organizations distributed funds, food, and personal protective equipment to residents using mutual aid strategies:

It was pretty obvious that we needed to figure out a way to start getting money funds to families. So, we started our own COVID relief fund and started getting people like through a kind of a mutual fund strategy, trying to get people to donate to that fund and then figure it out that way. (ID 05)

As a whole, interviewees emphasized that the needs of the community came first, and only then did they consider the means to the end. Field note data raised the question if organizations would accept funds that did not align with their goals out of need, but that idea was not represented in the interviews. One participant shared, "if it's completely outside of our scope of work, then it doesn't matter how much money they're offering" (ID 04). If interviewees perceived the initiative as something that would make meaningful impact, the technical aspects were not communicated as barriers to engaging. Rather, the technical aspects are barriers that

come into play when organizations are hesitant to engage, and then a long application or a lot of reporting requirements are seen as barriers to engagement.

#### **2.3.4.2 Doubts about Long-Term Impact**

Participants also doubted the potential impact of the initiative, with the short performance period of just a year and unclear metrics. Responding to the RFP, a participant annotated the phrase from the RFP “invest in communities most impacted by health inequity” and asked, “how is impact defined?”

One of the goals of the initiative was to address inequities in access to healthcare, information, and health outcomes, but participants saw the initiative as “lots of work to scale up quickly, only to then have to let people go” (ID 06). Participants stated that CBOs are open to starting new initiatives that meet community needs, but they should be sustained over multiple years. Otherwise, they will be wasting resources to get a new initiative started:

You're not going to expand for one year service for anything because you don't want to lay people off. [...] The 6 months it'll take you to get things off the ground to only produce 6 months of work. (ID 04)

The short timeline is a deterrent to applying because CBOs want to apply for grants that expand their existing capacity, rather than starting a new program area, even if it can fulfill community needs. A particular concern of this grant was that it included hiring 16 people at one time, and CBOs were concerned about what would happen to these individuals at the end of the grant:

It was just sort of like your funding is gonna end, and like you have trained all of these people and supported them and like there wasn't a clear next step [...]. So I have a lot of concerns about like, even if we did have the capacity to hire and train all of those people, what's the next step? (ID 06)

Especially without a guarantee of renewal, participants did not see this opportunity as helpful to the long-term capacity of the organization or to the benefit of the community. As one participant stated, “you can't expect the world to change on a shoestring budget. So, I think that there's a misalignment a lot of times between the amount of funding and the level of expectation of the

results” (ID 06). The long-term impact of the initiative was unclear, particularly as it pertained to addressing inequity in health outcomes. Interviewees suggested that the grant should describe next steps, like funding for organizations to keep those individuals hired and integrate them into the pre-existing programs, or potentially have a pipeline for the trained workers to get a job at a city department when the grant period ends:

In a perfect world the ideal thing would be [...] to like transition them back [...] to our direct service staff and have the funding to continue paying them. (ID 06)

## **2.4 Discussion**

This mixed methods study utilized field notes, interviews, and annotated RFPs from six interviewees who were leaders at small community-based organizations. Important themes that mark the decision for CBOs to apply to the public health funding initiative were how it related to the CBO’s scope of work, meeting the needs of the community, having the technical capacity, and cross-cutting themes of putting the community first and having a long-term positive impact. These findings highlight tensions between community-led public health and the neoliberal push for governments to contract out essential services.<sup>7,9,50</sup> The insights from interviewees suggest that initiatives like the one used in this case study should not assume that the government’s call will resonate with a variety of CBOs, and that they may not prioritize if and how their CBO collaborating will increase the capacity of the public health system. For instance, this RFP specifically called for organizations that did not do contact tracing and for organizations that were non-clinical. The funders assumed that the reasoning for this approach would be easily understood by organizations and that they would share vision of building local public health infrastructure, but that was not the case, as the themes of the initiative not being within organizations’ scope of work and not meeting the needs of the community were prominent. Interviewees voiced these concerns with the approach, and at the same time their organizations

were rapid in responding to community needs during the pandemic. Organizations demonstrated that they could responsibly and efficiently meet community needs with more funding, but still rejected the opportunity for this funding. While there is increasing funding for collaborative, CBO-contracted public health work, CBO growth and sustainability will depend on their willingness to have diverse, flexible scopes and innovate within the system.<sup>51–54</sup> To encourage this spirit of innovative involvement from CBOs, it might be useful to educate CBOs on how they do and can fit into the public health system better, along the vast domains of the essential public health services. For organizations, this research raises the question of what is the balance between participating in seemingly divergent opportunities (“selling out”) and expanding organizational mission and focus for a more sustainable impact?

These findings also draw attention to the system transformation that is needed in order to get full participation from CBOs. As interviewees described the RFP in this case study as typical, it shows that funders typically do not create opportunities with small, mission-driven organizations in mind. This might be because some CBOs, particularly smaller and grassroots organizations, are known for pointing out societal shortcomings and holding governing bodies accountable, with many examples in public health across issues such as clean water,<sup>35</sup> maternal and child health,<sup>12,33</sup> and gun violence.<sup>41</sup> Although governments resist being challenged, partnership heterogeneity is essential for addressing complex and diverse problems.<sup>15</sup> By creating this opportunity that did not match small CBOs’ interests, the LHD inadvertently excluded groups of CBOs that could strengthen the overall public health system. For small organizations in particular, this funding amount is not adequate for starting a new program that does not address the immediate needs of their service population. The small amount of funding coupled with the technical aspects of the application and program implementation are barriers to participation from small organizations. However, technical

aspects of the RFP minimally influenced organizations' decision to apply, so technical assistance workshops are not the solution to getting more varied participation from CBOs for public health initiatives. Interviewees emphasized that there must be funding that can be used to meet community needs, above all, and that opportunities should result in long-term impact. This research raises the question of how governments should respond: by accepting the absence of such organizations or by creating and re-creating different models for community organizations to participate in public health?<sup>50</sup>

#### **2.4.1 Limitations**

Due to small sample size of this study paired with the case study approach, and the specific “type” of CBO that participants represented, these findings have broad, but not specific, implications for CBOs applying to public health initiatives. First, the study had a small sample size of six participants and four who completed the RFP annotations, with the last 2 still elicited during the interview. Six participants showed evidence of saturation, as the main themes emerged after the fourth interview. Another limitation of this study is that participants were asked to comment and think retrospectively about the funding opportunity. Their perspective includes what they know now about the city's response to the pandemic and what they saw happened in their communities over the past two years. In addition, two of the participants were new to their respective organization (although not new to the nonprofit service sector). While their insights were rich, they may not completely represent what CBO leadership think when they come across funding opportunities. These limitations aside, the field notes over the past two years and my prolonged engagement in the initiative support the credibility and authenticity of the data.<sup>45</sup> These findings fulfilled the research goal of identifying reasons why CBOs might be reluctant to partner on government-funded public health initiatives.



### **2.4.2 Conclusions**

This study examined factors related to CBO non-participation in public health. This study yielded insights into what kinds of changes governments may need to make to elicit more involvement of small CBOs in public health, in the name of emphasizing collaboration. It is essential to understand and inform what governments can do to gain the participation of those CBOs that traditionally are unwilling to participate. Future research should aim to describe and learn more about how small, mission-driven organizations can be involved in public health, maximizing their strengths and assets while also increasing their capacity to grow and become sustainable. Future research should also examine the structural barriers to power-sharing and deep collaboration between the government and CBOs. Ultimately, this research would support a public health system that addresses the social and structural drivers of health in every community.

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### **3. WHO PARTICIPATES IN GOVERNMENT SPONSORED PUBLIC HEALTH: A CASE STUDY DOCUMENT ANALYSIS**

#### **3.1 Background**

Community based organizations (CBOs) fill many purposes within a community as avenues for public participation, advocacy, innovation, implementation, as watchdogs, and as bridges for problem solving.<sup>1-6</sup> Broadly defined, CBOs are institutions controlled within a community, and they contribute to community capacity in a variety of ways such as cultural organizations, communications organizations, faith-based organizations, and civic organizations that build individual assets in the community.<sup>7</sup> Local health departments (LHDs) increasingly partner with CBOs due to their familiarity with the community and trust that they have built over time.<sup>6,8</sup> This approach is part of Public Health 3.0, a “renewed public health approach” and a framework that describes the growth of public health from the 19<sup>th</sup> century.<sup>9</sup> The Public Health 3.0 vision positions partnerships with communities as essential in leading the charge to public health success and addressing issues in community health.<sup>10-14</sup> Collaborative efforts between governmental institutions and communities have a utilitarian value that improves the public health system by increasing cultural competency of staff and linguistic diversity,<sup>15</sup> creating links to community networks and community resources<sup>16</sup>, and leading to better outcomes that would not occur with separate, fragmented efforts of researchers, practitioners, and policy makers.<sup>17</sup> In addition, public health initiatives that include the community are valued from an empowerment or social justice perspective because people are given power to participate, influence, and hold institutions accountable.<sup>18,19</sup> With more community participation in community health, public health investments can more closely align with the lived experience of residents, increase community development capacity, and grow community resiliency.<sup>17,20</sup>

The government is the largest donor to the nonprofit sector,<sup>21</sup> but LHDs have far to go in becoming more collaborative with non-profit, community-based organizations. One analysis saw that out of 490 LHDs across the United States, only 41% had regularly scheduled meetings with community-based nonprofits and only 10% of LHDs had a written agreement with a community-based nonprofit, which would be indicative of a formal partnership.<sup>22</sup> In addition to the need for more partnerships generally, it is unclear what kinds of CBOs typically participate in public health initiatives. In data from the 2013 National Survey of Nonprofits, governments more frequently had agreements with larger nonprofits, with 47% of nonprofits working with governments had operating budgets of \$1 million dollars or more, and 36% with budgets between \$250,000 and \$999,999.<sup>23</sup> Another study surveyed human service nonprofit organizations in Maryland and found that bureaucratic orientation, stronger domain consensus, longer government funding history, organizational size, and organizational age were predictors of the number of government contracts and the amount of funding.<sup>24</sup>

There appears to be no research that specifically examines the characteristics of CBOs that participate in publicly-funded public health initiatives. It is important to examine who participates because partnership heterogeneity is essential for addressing complex and diverse problems at the root of social inequities.<sup>25</sup> From these observations raises the question: are community-based organizations that participate in government-funded collaborative initiatives significantly different than those that do not, and are they representative of the diverse assets of a community? There could be a lost opportunity to engage diverse CBOs with unique assets and opportunities. With a greater understanding of applicant CBOs' organizational nature and focus, workforce and organizational capacity, and connectedness to other CBOs, we might better understand current gaps and missed opportunities for partnering with CBOs.

## **3.2 Methods**

### **3.2.1 Design**

The guiding research question for this study is *what are the characteristics of CBOs who participate in an LHD-funded initiative during a pandemic?* This study employs a document analysis<sup>26–28</sup> to examine the characteristics of CBOs that applied to a large public health funding opportunity for a community level COVID-19 response in Chicago. Documents are considered “literary, textual or visual devices that enable information to be shared and ‘stories’ to be presented.”<sup>26</sup> Individual and collective lives, including actions and activities of CBOs, are marked by and with documents,<sup>26</sup> which are the data sources for this study.

### **3.2.2 Context**

This case study came from the Chicago COVID-19 Contact Tracing Corps, where Chicago Department of Public Health funded non-profit CBOs to serve as local employers of the City’s Contact Tracing Corps and in so doing, invest in communities disproportionately impacted by COVID-19 while creating a public health workforce that is representative of their residents. The City took requests for proposals (RFPs) in two rounds, with the first open to invited organizations who had a previous relationship with the coordinating organization, and the second open to any eligible organizations, defined as non-clinical, 501c(3) organizations that serve Chicago residents. The round 2 RFP was released July 28, 2020 and due August 17, 2020. Applications were scored on specific criteria by a team of reviewers. Scoring criteria included service to “high-hardship community” areas as defined by the LHD, experience with engagement of “hard-to-reach” contacts, COVID-19 prevention education and wellness education, identification of healthcare and assistance resources available in the neighborhood, and community engagement to increase support for contact tracing. Applicants were also separately scored on their financial information. Prospective applicants were told that the award



may be renewed for one additional term up to 12 months depending on programmatic need and CBO achievement of benchmarks and compliance with funding terms.

### **3.2.3 Data Collection**

To examine and compare the characteristics of CBOs that applied to the Initiative, I identified relevant characteristics of organizations from RFP extraction and literature synthesis, then I used these variables to extract data from round 2 applicant CBOs' websites and 990 federal tax forms. Table IV shows the extracted variables from CBO websites and the tax forms, which were recorded using a Qualtrics form.<sup>29</sup> Identification of the variables to extract from the data collection were guided by the RFP questions, since in the RFP, applicants were asked to describe their service delivery to specific populations in high-priority areas, the funding opportunity's alignment with the organization's vision and mission, how their experience would support success in completing the scope of work, their plan for establishing and supporting the new employees, and their fiscal resources and ability to manage the grant.

#### **3.2.3.1 990 Forms**

The first data source was information from organizations' 990 tax forms (**Table IV**). All 990 information was retrieved from the IRS.gov Tax Exempt Organization Search. When available, information from organizations' 990 form for the 2018-2019 fiscal year or the 2019 calendar year were extracted for this study, as this would reflect the most recent information that was used for the grant applications in June 2020. If organization did not file taxes for that time period, the most recent form was analyzed. Data collected from the 990 forms included the type of 990 (N, EZ, or regular) in order to trace reasons for missing financial data, as well as the ruling year, number of voting members of the governing body, total number of individuals employed, total number of volunteers, current year summary of contributions and grants, program service revenue, grants paid, salaries and benefits paid, revenue minus expenses, as

<b>Table IV. DATA COLLECTION VARIABLES</b>	
<b>Data Source</b>	<b>Variable</b>
CBO Website Extraction	<p><i>Dichotomous measures</i></p> <ul style="list-style-type: none"> <li>• History page</li> <li>• Financial Report</li> <li>• Annual or impact report</li> <li>• Donation link</li> <li>• Volunteer link</li> <li>• Events page</li> <li>• News page</li> </ul> <p><i>Qualitative Measures</i></p> <ul style="list-style-type: none"> <li>• Minority-founded</li> <li>• Community areas served</li> <li>• Mission statement</li> <li>• Populations served</li> <li>• Program areas</li> </ul> <p>Partners listed</p>
990 Tax Forms	<p><i>Organization Information</i></p> <ul style="list-style-type: none"> <li>• Ruling year</li> <li>• Number of voting members of governing body</li> <li>• Number of staff employed in the calendar year</li> <li>• Number of volunteers</li> </ul> <p><i>Financial Information</i></p> <ul style="list-style-type: none"> <li>• Salaries and benefits expenses</li> <li>• Revenue minus expenses</li> <li>• Revenue from contributions and grants</li> <li>• Program service revenue</li> <li>• Grants paid</li> <li>• Fundraising revenue</li> <li>• Revenue from governmental grants</li> </ul>

well as calculated revenue from fundraising and revenue from government grants.

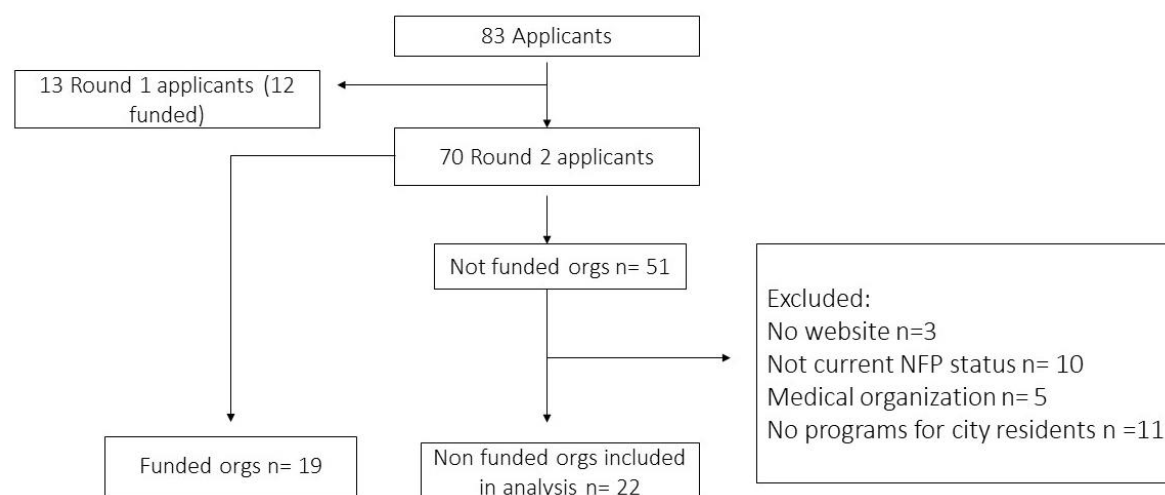
### **3.2.3.2 CBO Websites**

To gather information about the CBO's congruence with the scope of work, I conducted a document review of organizations' websites.<sup>26,27,29–31</sup> Websites were visited in February and March 2022. Variables mined from CBO websites included the mission statement, program types, any specific communities or populations named, the names of any partners or funders, and any covid-19 specific content (**Table IV**).

### **3.2.4 Inclusion Criteria**

This study only includes applicants to the round 2 RFP, since they are representative of organizations responding to a general call for applications. Organizations were included in this analysis if they met eligibility criteria of the grant: an active non-profit status at the time of this study—primarily performed service delivery, served City residents, and was not a clinical organization (see Figure 2). In addition, organizations were considered for inclusion in this study only if they had a website, since that is a primary data source.

**FIGURE 2. CONSORT diagram**



### **3.2.5 Analysis**

Data were analyzed using a mixed methods approach.<sup>32–34</sup> Variables from the 990 forms and dichotomous variables from CBO websites were combined into a single dataset. First, descriptive statistics of organization characteristics were generated and compared between funded and non-funded organizations. Due to high variability of variables extracted from 990 forms, these variables were grouped into intervals and then examined for significant differences between funded and non-funded organizations using chi-square tests for nominal variables and descriptive statistics and t-tests for scaled variables.<sup>35</sup>

Some website data were also examined using summative content analysis approach.<sup>36</sup> Mission statements were coded using a deductive coding approach. Mission statements were coded for key terms, and both groups of applicants named increasing service access, improving peoples' quality of life, advocacy, change, community, culture or arts, education, empowerment, justice or equity, workforce development and employment, housing, social, and addressing violence. In addition, partners identified on CBOs' websites were coded and categorized by type (i.e. a specific school was coded as "public school"). Program types were extracted from the websites and coded along broad categories of youth, child programs, workforce development, community development, business services, arts and culture, housing, violence prevention, social services, and "other". As websites were reviewed, sub-categories for each of these program areas were also identified so that each program could be briefly described using the same criteria. The program types were then counted for each organization and totaled to analyze quantitatively, as described above.

### **3.2.6 Study Advisory Board**

An important method integrated in this work is the involvement of a small, three member advisory board that provided feedback throughout all stages of the research. Advisory group

members were public health professionals in the city, each with unique experience of over 10 years ranging from grant writing, working with local public health departments, and working with CBOs. The advisory board was created in accordance with best practice, where those with varied experience could participate in data interpretation in order to better have a trustworthy and realistic interpretation of the data.<sup>37</sup> In relation to this study, members participated in the identification of methods and fields to include in the data collection. Member checking can also serve to elaborate categories and inquire to what extent they fit participants' experience.<sup>38</sup> As professionals who lead and work with CBOs, advisory board improved the analysis and interpretation of the findings.<sup>16</sup> Members were compensated for their time at \$50 an hour, with there being two, one-hour meetings for this portion of the study.

### **3.3 Results**

Community based organizations are described in terms of their organizational nature and focus, workforce and organizational capacity, and partnerships.

#### **3.3.1 Organizational Nature and Focus**

Organization characteristics were examined using a mixed methods approach to compare applicant groups. Funded and non-funded CBOs included those founded between 1915 and 2020. There were three applicant CBOs less than three years old, which were not funded. Looking across data collected from CBO websites, as expected, both groups had representation of minority-founded organizations and were located in high-hardship community areas. Both groups named serving Black and Latinx residents, non-native English speakers, veterans, unemployed people, people with disabilities, children, teens, refugee, immigrant, and justice-involved populations.

Qualitatively, there was variability in the missions of funded and non-funded applicants, with empowerment as the most common descriptor for organizational missions. Health and

service access were more common keywords among funded organizations, while education and economic impact were more salient targets among non-funded CBOs. Unique key words named among non-funded organizations included addressing trauma, addiction services, and mentorship.

Overall, both groups of applicants had a variety of program types, and applicants had multiple program areas and were not “one kind” of organization that focused strictly on health, workforce, or supportive services, for example (Table V). A higher percent of funded organizations had health-related programming, and more non-funded organizations had workforce development programs, although these differences were not statistically significant. Of the workforce development programs offered by applicant organizations, 50% of non-funded vs. 32% of funded offered programs that were apprenticeship, on-the-job training programs, or certifications. These programs included a youth summer employment program, trades programs, and apprenticeship and/or certifications in construction, distribution, logistics, computing, operating machines, culinary arts, welding, manufacturing, solar energy, nursing, customer services, commercial driving, electronic works, insurance sales, emergency response, protective services, retail, childcare, Information technology management, janitorial, and commercial sales.

About 65% of funded organizations had some kind of health program, with mental health services being the most common. Mental health services includes counseling (including for substance abuse) and crisis intervention services. Funded organizations were more likely to have a mental health program ( $\chi^2= 4.21$ ,  $p = 0.040$ ), and one funded organization had a mental health crisis line and was experienced in running a call center. About 45% of non-funded organizations had some kind of health program, with health promotion programming being the most common ( $n = 6$ , 27%). Health promotion topics included nutrition, stress reduction,

<b>TABLE V. PROGRAM AREAS BY ORGANIZATION TYPE N (%)<sup>a</sup></b>			
	<b>Not Funded (N = 22)</b>	<b>Funded (N = 19)</b>	<b>Total (N = 41)</b>
<i>Workforce</i>	17 (77)	12 (63)	29 (71)
Training Program	11 (50)	6 (32)	17 (41)
<i>Youth</i>	14 (64)	11 (58)	25 (61)
<i>Community Development</i>	9 (41)	5 (26)	14 (34)
<i>Health</i>	10 (45)	12 (64)	22 (54)
Clinical Services	1 (5)	3 (16)	4 (10)
Health Promotion	6 (27)	6 (32)	12 (29)
Mental Health Services*	3 (14)	8 (42)	11 (27)
<i>Business Services</i>	5 (23)	4 (21)	9 (22)
<i>Child Programs</i>	3 (14)	6 (32)	9 (22)
<i>Violence Prevention</i>	6 (27)	4 (21)	10 (24)
<i>Arts</i>	2 (9)	2 (11)	4 (10)
<i>Housing</i>	5 (23)	6 (32)	11 (27)
<i>Supportive Services</i>	9 (41)	8 (42)	17 (41)
*Statistically significant difference across funded and non-funded applicants, $p < 0.05$			
<sup>a</sup> Percents do not add up to 100% because each organization could have multiple program areas.			

physical activity, and trauma 101. Of the applicants, three funded organizations had a clinic or healthcare center, whereas just one non-funded organization had a clinic. Supportive services offered by organizations included case management, workshops in life skills, finance, etc., food distribution, referrals, drop-in centers, and public assistance application support.

### **3.3.2 Workforce and Organizational Capacity**

Components of CBO websites were examined quantitatively and shed light on organizational capacity to meet the scope of work outlined in the RFP.

Financial information from 990 forms was acquired for most funded applicants ( $n = 18$  out of 19), but only about half of non-funded applicants ( $n = 12$  out of 22). Non-funded

applicants did not have tax information available due to being newly funded ( $n = 1$ ) or not having enough revenue (\$50,000) that required them to report complete financial information ( $n = 9$ ). In addition, 4 non-funded organizations only filed a 990EZ, which provides information about total revenue and expenses, but not the amount of revenue specifically from government or fundraising contributions.

Results from the 990 analysis are included in **Error! Not a valid bookmark self-reference.** Within the funded and non-funded groups, there was a large variance in the number of staff, volunteers, revenue from contributions, revenue from government contributions, revenue from fundraising, and revenue minus expenses. Funded organizations had larger staff sizes, with a median of 28 staff members. Among funded applicants, 35% reported less than 20 staff members, 47% having 100-250 employees, and 3 organizations (18%) over 500 employees. In comparison, among non-funded organizations, they had a median of 17 employees, with half (50%) having less than 20 staff members, 42% with less than 250, and just 1 (8%) with over 500 staff members (and with the caveat that this particular organization reported data for their sites across multiple cities). There was no statistically significant difference between funded and non-funded applicants when comparing the staff size or number of volunteers. Funded organizations overall had more revenue compared to non-funded organizations. The three organizations with the

<b>Table VI. N (%) APPLICANT ORGANIZATION CHARACTERISTICS<sup>a</sup></b>
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shows applicant organization characteristics, comparing funded and non-funded applicants. There was a higher proportion of funded organizations that had organizational history on their website, compared to non-funded applicants (41% vs. 74%,  $p = .035$ ). A higher proportion of funded organizations had financial and annual reports, volunteer sign ups, events and news pages, although these differences were not statistically significant. Funded applicants



were also more likely to list or name any partners on their website, compared to non-funded organizations (84% vs. 55% respectively,  $p = 0.042$ ).

Financial information from 990 forms was acquired for most funded applicants ( $n = 18$  out of 19), but only about half of non-funded applicants ( $n = 12$  out of 22). Non-funded applicants did not have tax information available due to being newly funded ( $n = 1$ ) or not having enough revenue (\$50,000) that required them to report complete financial information ( $n = 9$ ). In addition, 4 non-funded organizations only filed a 990EZ, which provides information about total revenue and expenses, but not the amount of revenue specifically from government or fundraising contributions.

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Table VI. N (%) APPLICANT ORGANIZATION CHARACTERISTICS <sup>a</sup>			
	Not Funded	Funded (N = 19)	Total

	(N = 22)		(N = 41)
<i>Organization History Page</i>	9 (41)	14 (74)	23 (56)
<i>Founded by any minority group</i>	14 (64)	11 (58)	25 (61)
<i>Financial report</i>	1 (5)	3 (16)	4 (10)
<i>Annual Report</i>	7 (32)	10 (53)	17 (41)
<i>Donation Link</i>	18 (86)	16 (84)	34 (85)
<i>Volunteer Sign Up</i>	9 (41)	10 (53)	19 (48)
<i>Events Page</i>	10 (45)	11 (58)	21 (51)
<i>News Page</i>	13 (59)	16 (84)	29 (71)
<i>Names/Lists Any Partners</i>	12 (55)	16 (84)	28 (68)
<i>Number of Staff</i>			
20 or less	6 (50)	6 (35)	12 (41)
21-250	5 (42)	8 (47)	13 (45)
more than 250	1 (8)	3 (18)	4 (14)
missing	10	2	12
<i>Any volunteers</i>	8 (67)	11 (65)	19 (66)
missing	10	2	12
<i>Revenue from Contributions 1 Million Dollars or More</i>	7 (47)	13 (72)	20 (61)
missing	7	1	8
<i>Revenue from Government Contributions</i>			
missing	10	2	12
none	5 (42)	2 (12)	7 (24)
less than a million dollars	3 (25)	4 (24)	7 (24)
over a million dollars	4 (33)	11 (65)	15 (52)
<i>Any revenue from Fundraising</i>	6 (55)	5 (29)	11 (39)
missing	7 (47)	1	8
<i>Any revenue from Programs</i>	7	12 (67)	19 (58)
missing	7 (47)	1	8
<sup>a</sup> Percents do not add up to 100% because each organization could have multiple program areas.			

largest amounts of revenue were all funded organizations.

Although not a statistically significant difference, a higher proportion of non-funded applicants reported no funding from government sources (42%) compared to funded applicants (12%), and a higher proportion reported any revenue from fundraising contributions (55% vs 29%, respectively). Both non funded and funded applicants had a history of grantmaking. Among these, two funded organizations paid out over a million dollars each in grants, while three non-funded orgs paid \$380,244 combined. In addition, both funded and non-funded applicants had revenue from program services.

### **3.3.3 Partnerships**

Partnership information was retrieved for about half of non-funded organizations (n =12) and most of the funded organizations (n= 19). Both groups of organizations indicated partnership with other CBOs, clinical organizations, associations (e.g. American Medical Association, business associations), academic institutions, banks, corporations, houses of worship, foundations, small businesses, and government entities. Unique partners for funded organizations included individual schools and investment firms. In addition, non-funded organizations uniquely indicated partnership with museums, a union, and the media. Both groups of organizations also vaguely reported partnership with government institutions, including the Department of Health and Human Services, the Public School district, and the local government. Funded organizations reported specific partnership with public health and healthcare institutions such as the Cook County Department of Public Health, Illinois Department of Public Health, the Substance Abuse and Mental Health Administration (SAMHSA), the Centers for Disease Control and Prevention, and a state-wide health initiative. Funded organizations also reported partnership with Department of Corrections and Department of Family and Social Services. In contrast, non-funded organizations reported governmental partnership with the federal Small Business Administration, US Army, the Clerk of the Circuit

Court of the County, the state Department of Commerce and Economic Opportunity, and specific departments in the City including the housing authority, transit authority, and City planning agency.

### **3.4 Discussion and Conclusions**

This study aimed to describe CBOs who participate in LHD-funded public health initiatives and provide insights on if there are types of CBOs that are better able to participate in large, public health-funded initiatives. While there were a wide variety within CBO applicants, this funding opportunity seemed to favor those organizations that had history of larger amounts of government funding and more staffing capacity, regardless of specific programmatic expertise. This is consistent with existing research that shows history of government funding predicts the likelihood of obtaining future government funding.<sup>24</sup> Almost half of non-funded applicants did not have enough revenue to be required to file a 990 form and non-funded applicant organizations tended to have small staff sizes. Even to apply, organizations needed to have capabilities around billing, which likely excluded some smaller CBOs that did not yet have sufficient capacity. The capacity of organizations was also reflected in CBOs' ability to routinely update websites. Although there seemed to be less capacity among the non-funded applicants, non-funded applicant organizations had clear strengths as organizations that could fulfill the programmatic scope of work outlined in the RFP. Non-funded applicants had just as much workforce development programs, a variety of health promotion activities, and partnerships that focused on the social determinants of health. Considering that the majority (67%) of public charities have expenses less than \$500,000 a year, and 30% have expenses less than 100,000 a year,<sup>39</sup> there may be a lot of organizations that do not have the capacity to engage in public health as the opportunities are currently structured, even if they are skilled enough to complete

the scope of work and bring assets necessary for the work like credibility with community, social capital etc.

These findings draw attention to the need for opportunities for smaller, grassroots organizations that address social determinants of health to engage in public health work. Effectively working with communities requires enlisting civic and community leaders, including those at the grassroots level, rather than just at larger not-for-profit organizations.<sup>9,25</sup> Grassroots organizations are a specific kind of CBO that are committed to working within the community where it is rooted and centers the needs and voices of that community to address a social problem.<sup>40,41</sup> They are called “grassroots” because they make change from the ground up, typically employing community-based approaches to address localized issues. Scholars note the important, unique strengths of small and grassroots organization in government coalitions and partnerships.<sup>25,42–46</sup> A major strength of small organization is their flexibility and adaptability,<sup>45</sup> which can greatly benefit the public health system. Grassroots organizations are also known for enacting local change across multiple levels of the socio-ecological model and having hyperlocal impact.<sup>40,44,47</sup> Particularly for engaging hard-to-reach or hidden populations, working with small community-based organizations with social capital with those particular groups is essential.<sup>46</sup> In addition, they are directly connected to the issues and people being served, empowering vulnerable populations and collective action.<sup>1,40,41</sup> Furthermore, the involvement of community leaders such as executives of grassroots organizations can further legitimize a government-led initiative and increase cooperation and support because they are a part of the community.<sup>43,48</sup>

With the need to expand opportunities for small organizations, there are inevitably tensions within the nonprofit industrial complex.<sup>6,49</sup> There must be attention paid to how the system can change for organizations, but also how organizations can be supported to better

participate. First, the system must change to be more open to innovative organizations. The structure and function grassroots organizations tend to be less bureaucratic and more critical of government,<sup>1,44</sup> leading to a prioritization of collaboration with hierarchical, high-capacity non-profits.<sup>41</sup> If government-funded initiatives intend to gather support from smaller organizations that do not fit the mold of public health partners, there must be an environment that provides opportunities for innovation so that these organizations can thrive.<sup>50</sup>

There is also a need to strengthen smaller CBOs so that they can participate in the public health system. The fact that funded organizations more often reported partnerships with public health institutions suggests that these organizations were better networked for engaging in public health work. Social capital is an important predictor of organizational success.<sup>45</sup> If those organizations had worked with and/or were known by the funder before in any capacity, that could favor particular organizations.<sup>24,51</sup> In addition, organizations that are better networked may have received informal technical assistance or advice when applying for the opportunity. Potential areas of intervention could be technical assistance offered to grantees or prospective applicants to strengthen their capacities.<sup>13,19,52,53</sup> Another opportunity is that CBOs could be strengthened by partnering more informally through coalitions or collaboratives,<sup>54-56</sup> ultimately supporting their capacity for future public health initiatives.

The narrow focus on CBOs participating in public health are high-capacity non-profits with large paid staff and hierarchical power structures limits our understanding of how all institutions within a community can support the public health system.<sup>41,57</sup> This study only includes clinical, 501(c)3 organizations with programs for the community, and there may be many other organizations that could have performed the scope of work for the grant, if they were included. It is essential to explore other avenues for LHDs to engage these types of stakeholders, whether it be a different partnership structure, or something more integrated into

initiatives, like coalition structures or advisory boards. If the goals of Public Health 3.0 are to be obtained, public health funders, including LHDs, must commit to working with the unique strengths of grassroots organizations while allowing for flexibility for each's structure and capacity.

### **3.4.1 Limitations**

This research has some limitations to be considered. First, CBO websites may not describe applicant organizations' mission and programs from when they applied for the grant in 2020. Since websites were reviewed about a year and a half after the grant, the results may better reflect current organizations' positioning for similar grants in the future, rather than their position at the time of the grant application. Second, information extracted from websites is limited and may not authentically reflect the complete whole of CBO partnerships and programming.<sup>28</sup> Specifically, the variable "partnership" does not have a specific operationalization for this study, as a "partner" referred to by the CBO might be a funder, a group that shares information about programs, or a more collaborative partner. A future study might explore the role of existing partnerships through an analysis of which organizations received technical assistance and how they found out about the RFP based on the networks they were a part of. In addition, future research might conduct a more robust review CBO activities through a standardized analysis like that of a survey or analyzing a standardized grant application with detailed descriptions of these constructs.

### **3.4.2 Conclusion**

Even with limitations, this case study yields useful information that can guide the development of RFPs that cater to community-based organizations with varying capacities. Non-funded organizations tended to have smaller staff sizes and less history being funded by government, but still many partner with entities across the city, including government entities.

Despite barriers to participating in public health efforts, organizations still wanted to participate. It is important for funders to consider the organizational strengths of community-based organizations, including those grassroots organizations with a small but mighty staff. More research is needed to describe the strengths that grassroots organizations bring to the public health system and identify the barriers that prevent them from participating in public health initiatives- both internal and external. This work would help develop opportunities where all CBOs can fairly compete for funding that plays to their strengths, the public health system can become stronger and better address health equity.



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## **4. A PICTURE OF COMMUNITY-LED PUBLIC HEALTH: INSIGHTS FROM COMMUNITY-BASED ORGANIZATION LEADERS**

### **4.1 Introduction**

To advance health equity, participation from the entire public health system is required, including governing bodies such as departments of public health, planning, transportation, recreation, healthcare organizations, and other partners across the whole community.<sup>1-3</sup> Over the past few decades, there has been a dramatic increase in funders requiring community-engagement<sup>4</sup> and supporting community-based and participatory research in public health, for the purpose of better addressing social and structural determinants of health.<sup>4,5</sup> There is an increasing value for a community engaged-approach because community ownership and control yields better outcomes and more sustainable efforts, and participatory processes allocates resources more efficiently for health equity.<sup>1,6-8</sup> One way that governmental organizations such as local health departments (LHDs) attempt to implement community-led public health is through collaborating with community-based organizations (CBOs) to fulfill roles in service delivery, public policy process, and governing.<sup>9</sup>

There are many models and tools that describe community engagement occurring along a continuum from community-informed to community-led.<sup>10-14</sup> With a community-informed approach, visions for change are set by the government, but are adapted to suit the local context through community consultation such as a community forum or focus group with residents.<sup>10</sup> Next, community-shaped approaches allow the local vision for change to be defined by the community within a set of parameters determined by the LHD.<sup>14</sup> In this stage, communities provide ongoing in-depth input and provide feedback to the LHD as partners, and strategies might include comprehensive community consultation and bridging and can look like the use of longstanding advisory boards, community health workers or promotoras.<sup>10,15</sup>

Community-driven approaches are ones where the local visions for change are created in partnership with community members and organizations, who share resources and collaborate to set parameters and decisions.<sup>14</sup> This approach requires power-sharing, which requires more investment of time and staff resources.<sup>10</sup>

A community-led approach is one that is community-owned, where community priorities are defined and implemented by the community, who are in control of all the resources, parameters, and decisions.<sup>14</sup> Community-led and community-driven approaches are marked by strong community leadership, final decision-making at the community level, in which the communities may consult with external partners for technical questions, and the outcomes reflect the needs and desires of the community.<sup>4,16</sup> Shared leadership is evidenced by a strong bidirectional relationship and communication, decision-making equally shared, entities have formed partnership on every aspect of the project, and an outcome is partnership and trust-building.<sup>4,16</sup> One end of the collaboration continuum is associated with more authoritarianism and lack of accountability and the other end represents more democratic and egalitarian approaches,<sup>17,18</sup> which makes ideal collaboration a structural challenge for governmental institutions that are traditionally bureaucratic and hierarchical.

Collaboration has the potential to distribute power and responsibility to the community,<sup>19</sup> but for this to happen there needs to be a shift in the traditional structures that were created to separate government from citizens.<sup>20–22</sup> In a systematic review of environmental protection agency request for applications from 1997 to 2013, only 16% discussed elements of community engagement, and researchers saw that community participation was the most frequently discussed level of community engagement.<sup>4</sup> More recently has there been emphasis been on meaningful collaboration, but there needs to be an investment in structural changes within local health departments if they hope to genuinely collaborate with CBOs.<sup>20,21</sup> The typical process for

fundes is to create an initiative and issue a call for proposals, and then invite the community to participate.<sup>23</sup> The problem with this is that successful collaborations do not start with collaboration itself, but instead occurs later in stages.<sup>24–27</sup> Community stakeholders engaged to do the work are expected to comply with the requirements of working in a bureaucratic structure.<sup>28</sup> The strongest collaborations begin with building a shared agenda or common ground, establishing roles, building trust, identifying project goals, and then begin collaborating.<sup>15,17,24</sup> Ignoring the process of collaboration reduces its potential to truly have a health justice impact. Further, community organizations and other partners may be included in initiatives as a form of tokenism.<sup>17,20,21,29</sup> In public health collaborations, there tends to be an image of involvement that does not allow the involvement to influence the core of organizations—giving a voice for the community with no power.<sup>20,21,29,30</sup> Furthermore, these processes can delegitimize the community’s own forms of self-organization<sup>28</sup> and their own skills and expertise.<sup>20</sup> Within this process, the government falls short of empowering the community<sup>19,21</sup> and the only well-supported initiatives are those aligned with the state agenda.<sup>29</sup>

There is a rich body of literature about collaboration including its facilitators, barriers, and outcomes, but local health departments (LHDs) struggle to collaborate with CBOs.<sup>31</sup> There is a large body of literature suggesting that organizations need capacity building or empowerment to meaningfully engage in decision-making, but less literature about the necessary culture shift at governmental organizations who fund public health work.<sup>26,32</sup> Local health departments that engage community health partnerships should understand the context of the partnership, including internal and external stakeholders, community’s capacity and resources, extent of previous experience, and current challenges facing community.<sup>10,23,33</sup>

While literature states that the public health system needs to be transformed,<sup>34,35</sup> the path forward for governments to share power to support community-led public health is unclear.



Health is political, so it is important to discuss health as a political outcome with political determinants<sup>36-39</sup> and critically assess how power systems and structures, institutions, processes, interests, and ideological positions affect collaboration for public health. Despite the influence of politics on health, inquiry along these intersections is not common.<sup>36</sup> Using a qualitative approach, this study aims to explicate what an optimal community-led approach looks like, from the perspective of smaller, grassroots organizations that do not readily want to participate in LHD-led initiatives.

#### **4.2 Methods, Approach, and Analysis**

This study uses a specific public health initiative from Chicago as a case study. The initiative called for non-clinical not-for profit community-based organizations to rapidly hire, train, and manage at least 16 individuals that would make up Chicago's contact tracing corps. This initiative was communicated as one designed to invest in communities disproportionately impacted by COVID-19 while creating a public health workforce representative of the residents. The RFP was released twice, with the first round open July 16, 2020 to July 30, 2020 for organizations that were invited as previous partners of the managing organization, and the second round was open July 28, 2020 to August 17, 2020 for any eligible organizations. The anticipated contract commencement was September 2020 and organizations about be awarded about \$800-900,000 for the year-long contract. There was one technical assistance webinar for each RFP, and prospective applicants were also told that funding may be renewed for an additional 12 months depending on the programmatic need.

Using a critical, social constructivist lens,<sup>40,41</sup> I employed a mixed methods research design to explore what informs a CBO's decision to engage in a government-led public health initiative. First, I conducted a series of face-to-face 90-minute semi-structured key informant interviews with leadership from CBOs that did not respond to the initiative's RFP. The goal of

the key informant interviews was to understand knowledge, attitudes, and beliefs of CBO leadership along the domains of the context of the opportunity, congruence between the goals and values of their organizations, and their own organizations' capacity and readiness. Individual interviews are a useful method for exploring topics in depth and result in rich information about personal experiences and perspectives, especially for sensitive topics such as frustrations related to the public health system or lack of funding.<sup>42,43</sup> The use of individual interviews is also exemplified in health research<sup>42</sup> and governmental research.<sup>20,29</sup> This study is a secondary data analysis of the interview transcripts to understand what a community-led public health initiative looks like.

#### **4.2.1 Community Engagement**

In this study, I centered the expertise of stakeholders who share a similar social context at every stage of the research.<sup>44</sup> The study was informed by a 3-member advisory board that was convened at the start of the study. The advisory board addresses potential biases such as assumptions and preconceived ideas that come with people being studied but not those doing the studying.<sup>44</sup> Advisory board members were intentionally recruited to bring diverse experiences as non-profit executives, board members, and technical assistance providers who each hold at least a master's in public health degree. The advisory board met three times and provided feedback throughout different stages of the study. First, advisory board members provided feedback on the recruitment flyer to exclude jargon and use words that were familiar to the target audience. In addition, advisory board members helped refine the interview guide. Lastly, members also were engaged for member checking, which is explained in the analysis section. Members of this advisory board were compensated for their time, at \$50 per hour.

#### **4.2.1 Sampling and Recruitment**

Participants were recruited through a recruitment flyer was shared on listservs with funders, research networks, and through word-of-mouth referrals from the author and the advisory board members. Interested individuals were assessed for eligibility in the study via a brief survey distributed over email. Eligible participants were over 18 years old, employed at a not-for-profit, non-clinical community-based organization in the city that did not apply for the initiative; and had a position where they participated in decision-making related to applying for RFPs. After assessing eligibility and reviewing study information, interested individuals were enrolled for participation in the study and scheduled for an interview according to their availability.

#### **4.2.3 Key Informant Interviews**

A semi-structured interview guide was created and was structured to cover the domains that influence a CBO's decision to apply: the context, the congruence, the organization's capacity and readiness. Participants were asked to describe their context, namely share information about organization, including their service population, programs and services, how they are funded, how they assess community needs, how they responded to the pandemic, and how they see their organization as part of the public health system. Participants were also asked about their process and history of responding to RFPs, namely governmental and public health RFPs, as well as history of partnering with government entities for public health initiatives. Lastly, participants were asked about the initiative's RFP in terms of how they assess their CBO's ability to fulfill the scope of work, how it fits with their capacity, and other aspects of the RFP that discourage them from applying. The number of interviews was determined based on saturation.<sup>45</sup>

The interviews were conducted on zoom and audio and video recorded with automatic transcription. At the end of the interview, participants were asked to complete a brief demographic questionnaire that captured their gender, race/ethnicity, and highest level of education completed. These measures were used to capture these social identities of participants' responses to contextualize their responses and consider the diversity of the perspectives they bring.<sup>44</sup> In exchange for their time, participants were compensated with a \$100 visa gift card, electronically delivered to their preferred email at the completion of the interview. Interviews were conducted in March and April 2022. The procedures of this study were approved by the University of Illinois Chicago Institutional Review Board.

#### **4.2.4 Field Notes**

A third data source used in this study are field notes.<sup>46-48</sup> I was involved in the initiative as a research assistant for the UIC School of Public Health, I approach this project with an insider/outsider perspective. This perspective is useful to research because prolonged engagement supports the credibility of the data.<sup>49</sup> I reviewed and scored 5 CBO applications during the round 2 funding, and since then I have primarily been involved with CBO support initiatives throughout the project, providing feedback to funded CBOs in a limited capacity, taking notes, and preparing materials for presentations from our team. During the first year of the initiative, I attended weekly meetings with CBOs during their check in meetings, attending and planning activities at the regional community of practice that is for CBO leadership, and attendance at other meetings with CBO stakeholders. As a participant-observer, I maintained field notes since August 2020.

Field notes include salient ideas that were noteworthy or interesting during meetings with project partners and events or meetings with funded organizations.<sup>47,48</sup> These salient ideas included both observational notes about what happened and what people communicated as well

as theoretical notes, capturing themes and ideas raised during the field experience.<sup>46</sup> In particular, the field notes allowed me to reflect on my own participation in this project and document ongoing observations and potential biases.<sup>48</sup> The notes were organized chronologically in a single notebook and were later typed up and imported to the qualitative analysis software for reference.

#### **4.2.5 Analysis**

An inductive discourse analysis was conducted with attention to how CBO leadership talked about the work that they do, the role of the governmental funders, and how power-sharing occurs in public health collaborations.<sup>50,51</sup> Discourse analysis is an analytic approach that is concerned with uncovering meaning, including hidden meanings, and how they call for action. This method builds on the idea that speech is a form of action- the way individuals talk about something has consequences from which we can make inferences about power relations.<sup>50</sup> Discourse analysis is an analytic framework that is useful for engaging with data using a critical view, asking questions about power and knowledge.<sup>51</sup> To conduct a discourse analysis, I approached the data with the following questions in mind: <sup>50</sup>

- What discursive resources are used to describe what community-led looks like?
- What assumptions underpin what is said about public health system and actors?
- What kind of discursive resources are being used to construct meaning?
- What are potential consequences or implications of the discourses that are used?

To analyze the transcripts in depth and after the first reading of the text, I conducted coding in two rounds. The first round of coding was descriptive coding, which will be primarily nouns that summarize the topic of the datum.<sup>52</sup> The second round of coding uses values coding,<sup>52</sup> identifies the values, attitudes, and beliefs of participants. This coding methodology requires inference and reflects what participants value as important, how they think or feel about themselves, and what they believe is true or necessary. The values codes were informed by the

first, discursive reading of the transcripts. After identifying main insights, field notes were consulted to compare with insights and expound descriptions.

After conducting the analysis, I conducted member checking with advisory board members. Member checking is taking ideas back to participants for their confirmation and it supports the credibility and confirmability of findings by providing input from CBO leadership to guide the study's data collection, analysis, and interpretation. This process can also serve to elaborate categories and inquire to what extent they fit participants' experience.<sup>53</sup> Member checking is a commonly used technique that allows for improving analysis findings.<sup>49</sup> Advisory board members also helped to group data and consider the implications for public health practice. Members of this advisory board were compensated for their time, at \$50 per hour.

#### **4.2.6 Description of Dataset**

Six key interviews were conducted with executive directors and program directors working in the Chicago community-based organizations (CBOs). Table III shows interviewee characteristics. Although some participants were relatively new to their role (i.e. ID 1), they had decades of experience at other CBOs as both program staff and in leadership roles. Interviewees belonged to organizations that had programs in areas of civic engagement, advocacy, violence prevention, youth development, case management, and community resource centers.

#### **4.3 Results**

Interviewees thought of their organizations' ability to make lasting change as dependent on governmental decision-makers' ability to share power. A field note documents an observation that CBOs focus on downstream determinants of health such providing access to vaccines, while addressing upstream factors like disinvestment in community health centers is the full responsibility of the government. Interviewees recognized that their CBOs bring innovative

problem-solving, something that is necessary for the public health system: [The public health system is] afraid to change and use a different approach [...] so it takes us people of color to say, 'hey, I tried it. I'm here, let's give it a shot.'" (ID 01) As recorded in a field note, CBO leaders understand the sentiment that "[this work] can't happen without the community [...] they need us." CBOs can only impact the upstream factors if they are given power to influence decision-making. In explicating what a community-led public health approach would look like, three insights emerged from the triangulation of interview data and reflective fieldnotes: giving up control, created spaces, and systems demonstrating trust in CBOs.

#### **4.3.1 Giving up Control**

Interviewees spoke with awareness that the powerholders are the governmental offices that dictate how much public health funding is available and how it can be used. The governmental decision-makers were described as "other" by the interviewees, as people downtown who did not identify with the people in the community or those doing the work. As one interviewee voiced: "I always point towards the east, like in the downtown area, and then they tell us was best for down here [on the south side], and that's not always so" (ID 01). Interviewees knew that in order for the voices of the community to be heard, the city government needs to give up power.

Participants linked the lack of power sharing with the government maintaining control, using words like "guardrails" or "safety" when describing what the opportunities to engage look like. Having closed spaces with set norms of engagement prevented disagreements and an interviewee recollected that "whenever you would voice a concern that was outside of that parameter that was established of what's safe to talk about there, you would quickly not be invited, or be [...] ignored" (ID 04). As a result, lack of disagreement stifles the potential of what the organizations could do and innovators, as one participant reflected:

There's no space for innovation or for something new. It's kind of like, this is the plan, and this is what we're gonna talk about'. Like 'we're gonna talk about vaccine events.' Not a different way of distributing vaccines. (ID 05)

One participant dreamt of a health department that gives up control:

I wish that there was also a space where we can envision kind of like, removing the guard rails. And what would that look like? You know, what would it look like to really invest in public health? But you know the fact that those conversations are not allowed to happen, there lies the real point. (ID 05)

For participants, power-sharing looks like the governments giving up control and allowing CBOs to create the agenda or set priorities. Participants talked about how traditionally, the City government decides what the health priorities are, and most of the time any priorities that are not aligned with the city's plan do not get funding or support. Field notes documented repeated frustrations with the governmental funder not attending project meetings, but then making decisions that impacted the whole initiative. One interviewee specifically talked about the ability to “define a win” for his community, which may be different than what a city funder would dictate or describe. Defining a win was important in his eyes because realistic goal setting is essential to program success. Another participant gave an example of how Asian American communities were excluded from some funding opportunities because they were not defined as “high need” by the city and other governmental metrics, although they had technological, cultural, and language barriers like other populations across the city:

[We] asked about whether the Illinois Department of Public Health can count would consider accounting language and culture as an additional barrier, and they and they more like [...] ‘we are going by the metrics [...] the CDC has, and so on, which are basically covid infection rates and morbidity rates and access to vaccines. [...] It’s unfortunate that sometimes Asian American communities are seen as not as needy. When it’s that the needs are different, not that there are fewer needs. (ID 02)

#### **4.3.2 Created Spaces**

All interviewees mentioned the figurative “table” where stakeholders come together to make and implement decisions. The table was recognized as an important site because



All of [the funding opportunities are] a result of the dialogues that you know have taken place, and then it's shaped into these opportunities for us to then step up and roll out the services and support. [...The funders are] doing the best they can with the information that they can see. (ID 03)

The construct of a table is reminiscent of what scholars call spaces of participation, which are social products that are a constructed means of control, and they provide opportunities, moments, and channels where people can act to potentially affect policies, discourses, and decisions.<sup>54,55</sup> Participants voiced frustration with existing spaces because they are closed spaces that are open by invitation only. Instead, interviewees shared that tables should be inclusive and designed for power-sharing, open for whatever organizations want to attend—what is known as created spaces. Particularly for planning and implementing programs, interviewees suggested that “the people closer that are gonna be managing the people, they need to be at the table to share input” (ID 01). Another interviewee described the need for created spaces:

There needs to be serious public health people at the kind of center of it, helping to organize the space and [...] create the table, for lack of a better word. I think it should be, you know, much more open than what it is [...] There's no reason for it to ever have been exclusive. Which is what it is right now. It's like you have to be invited to the table. (ID 05)

By “serious public health people,” this interviewee implied people with decision-making power at the city government level should be present, rather than representatives that do not have power to make decisions. CBOs should not be invited to spaces where their perspective and expertise does not count—they should be present in spaces where decisions are influenced.

#### **4.3.3 Systems Demonstrating Trust in CBOs**

Interviewees pointed out that the government verbalizes value for their organizations' work but noted that the structure of collaborations demonstrates a lack of trust in CBOs' work. Giving up control is something that could be demonstrated by the presence of open spaces, as well as investments in built infrastructure that allows for and encourages power sharing.

Interviewees their organizations' strengths, they found their strengths were not valued by government entities, and instead they had to "prove" themselves to funders:

I think that [our model] has a potential to be a really powerful tool. And so, I think to the extent that government entities can be open to innovation in a way that we don't have to try to prove that we work within a really short window of time ...] (ID 06)

Interviewees suggested specific structural changes that would indicate trust and allow organizations to share power with the government: flexible funding, and relaxed reporting requirements. First, participants raised the issue that many grants or contracts provide limited funds for administrative support and organizational costs for human resources staff, program directors, or potentially new staff (if hiring is not required by the contract). The lack of funding to support ongoing organizational needs says something about the value that funders put on what these organizations bring to the partnership. One participant, when talking about the respect that they received as first responders during the pandemic joked, "it was great [for our organizations] to be supported, but also [that partners] respect us as frontline workers [...] even though we didn't get the hazard pay. It's all right." (ID 01). Another participant reflected that funders should support their existing work with grants: "I want people to pay us for work that we're already doing and like adding on a little something, right?" (ID 06).

In addition to funding that could be used for administrative costs, participants saw that the administrative requirements of grants and contracts is typically overbearing and not consistent with the purpose for monitoring:

I don't think the level of scrutiny matches the level of fraud that exists, within organizations. So, I feel like there could be a happy medium between 'here's money don't tell us how to use it,' and like, 'tell us how every single penny was spent.' (ID 06)

In addition, interviewees spoke about how strict reporting requirements or lengthy applications took away from the work that they need to do, saying "it's like the more restrictions you put in place, [...] the more administrative burden you're putting on them, prevents them from

doing their work” (ID 06). Another participant gave an example of a federal grant that took at least 15 hours to write and more hours to submit using the application portal, reflecting that “[the application process ends] up being a lot of work for a smaller organization” (ID 03).

#### **4.4 Discussion and Conclusions**

The goal of this secondary analysis was to explicate what a community-led public health approach might look like, as depicted by six leaders at community-based organizations in the language they used to talk about applying for public health funding opportunities. In these findings, a community led approach was conceptualized as one that includes the government giving up control, created spaces, and systems demonstrating trust in CBOs. In order for public health to be community-led, there must be a commitment to power-sharing from the government decision-makers. The spaces where decisions are made restricts or releases CBOs’ ability to contribute to the movement for health equity.

This analysis emphasizes the need to attend to the political determinants of health when conceptualizing public health system transformation. The political determinants of health are norms, policies, and practices that arise from transactional interaction that cause and maintain health inequities.<sup>36,37</sup> The concept of political determinants of health draws attention to the policy systems and structures that affect health both directly and indirectly—including structures of collaboration. Interviewees talked about the governments’ theoretical appreciation for what people and organizations bring to public health, but this appreciation is not institutionalized in the structures and spaces of participation. This is a notable characteristic of neoliberalism. Neoliberalism is a political-economic theory, a set of economic policies, and a system of power that favors a free enterprise and a competition-driven market, so it favors reduced public expenditure on social services in order to strengthen the private sector.<sup>37,56</sup> Neoliberalism leads to a commodification and privatization of health and results in those with political power working

for corporate interest or concern with saving money over the needs of the people. Even within cross-sector collaborative processes, neoliberalism is an underlying value with which LHDs operate, putting greater emphasis on collaboration as beneficial due to its resource-saving or efficacy outcomes in efforts to save time and money, rather than emphasizing collaboration for its health justice potential. This is evident in the lack of investment in community-led public health, pitting organizations against each other to compete to provide essential services, instead of taking time and resources to cultivate spaces that bring each group together to envision and design action towards collective goals. The charge here is for public health institutions to allow CBOs to create spaces so they have leadership in public health that are non-hierarchical and non-bureaucratic. Created or claimed spaces are where empowerment takes place and less powerful actors can define the space and shape a healthy culture of participation.<sup>54</sup>

These findings also point to the need for governments to codify trust in CBOs in the structure of the partnership. It is unrealistic for governments to expect every organization to willingly participate in closed and invited spaces, and even more unrealistic to expect that communities will be empowered by this approach.<sup>29,57-61</sup> Structural factors that demonstrate trust is important for collaborations because it shows that organizations are respected as experts in their field.<sup>12,62,63</sup> Interviewees described collaboration like tokenism, where the heaviest burden is put on people of color and disenfranchised groups while they are not appropriately paid and recognized for their labor.<sup>17,20,21,29,30</sup> Interviewee's suggestions for flexible funding and reporting requirements coincide with examples from trust-based collaboration<sup>63</sup> and trust-based philanthropy.<sup>12,33,64</sup> A trust-based approach addresses concerns around equity in grantmaking by going beyond traditional programmatic restrictions in grantmaking and places trust in organizations to use resources in ways that meet the needs of their staff, programs, and communities they serve.<sup>64</sup> There are examples of trust-based

collaborations, but they are not the norm.<sup>62,63,65</sup> Scholars describe a trust-based relationship between governmental funders and program staff from partnership organizations funded to do family violence prevention services.<sup>63</sup> Structural factors related to success included a detailed service purchase agreement that was a living document that was open to modification so that it accurately describes the services that organizations wish to provide for family violence prevention. Soliciting and acting on feedback and being transparent and responsive are important characteristics of collaborations that foster trust.<sup>63,64</sup> In addition, trust-based collaboration has more flexible funding formula, for example allowing organizations to keep their surpluses and did not pay for deficits, which creates incentive for organizations to control a budget well and respect organizations' independence.<sup>63</sup> Another element of trust-based collaboration is a low level of monitoring and streamlined paperwork.<sup>62,64</sup> An example of this is quarterly, simple reporting requirements that maintain communication between program staff and organizations.<sup>63</sup> If local health departments and other funders value CBOs because of the innovation and creativity they bring, there should be structures in place that elevate the voices of CBOs and allow them to bring their perspective to the planning, implementation, and evaluation of public health initiatives. The form and content of a collaboration agreement and the processes used to formulate them affect collaboration outcomes,<sup>13,60</sup> so changing how initiatives begin and are formulated will improve overall collaboration and its outcomes.

#### **4.4.1 Limitations and Conclusions**

This study is not without its limitations. One limitation is that the study only includes 501c(3) organizations that had paid staff. While the conclusions might apply to informal volunteer organizations, the perspective of volunteer organizations or non-registered community-based organizations are not represented in the data. There is need to understand what community led public health can look like for various types of organizations that could be

considered community assets, such as block or neighborhood groups, tenant associations, church volunteer groups, youth groups, and merchant associations.<sup>66</sup> Much of the time, these types of organizations are ignored in the research but still sites of innovation.<sup>67</sup> Future research should examine the perspectives of various types of organizations to understand how they too can become more involved in the public health system, and how the life course of the organization changes due to their involvement. Another potential limitation of this study is that the participants brought a specific perspective as executive directors and program directors that volunteered for an interview about community-led public health. These findings may not represent the perspectives of CBO leaders that are completely disinterested in formally engaging in public health work, or of program staff that are in the same spaces as their leadership.

Despite these limitations, the interviews yield rich information that can be used to guide system change that allows for more community-led public health initiatives. These findings shed light on the ways in power-sharing can be actualized for local health departments. There must intentional efforts for governments to give more control to CBOs and support an infrastructure of created spaces marked by power-sharing, equity, and innovation.

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## 5. CONCLUSIONS

Using a case study approach, this research provides a critical perspective on collaborative governance that informs the development of alternative ways of governing and administering cross-sector collaboration. The Chicago COVID-19 Contact Tracing Corps presents a localized example of addressing urgent public health concerns around COVID-19 inequities in infection, hospitalization, testing, and vaccination. This research is important because LHD-CBO collaboration is increasingly common and funded, but not executed with attention to equity.<sup>1-5</sup> This research has a wide reach—of all government contracts and grants to not-for-profit organizations, over half go to human services organizations, like the CBOs included in this study.<sup>6</sup> The 2013 National Survey of Nonprofits saw that not-for-profit human services organizations had over 80 million dollars in government grants and contracts, with an average of 2.8 million dollars in government grants and a median of \$387,732.<sup>6</sup> Without community-led public health, these millions of dollars are not being used to their best efficiency, and there is a missed opportunity for empowering communities and advancing equity. This research bridges a theory-practice gap by informing how LHDs and other funders can better design opportunities that are acceptable and accessible to CBOs that serve historically disinvested communities, and how CBOs need to reconcile the tensions between participating in existing opportunities for public health while pushing for innovative change. The findings from this study inform the path forward to community-led public health within a bureaucratic system of collaborative governance.

### **5.1 Inviting All CBOs into Public Health**

Public Health 3.0 emphasizes the need for collective impact to improve the social determinants of health.<sup>7-11</sup> The public health system needs both task-oriented, professionally dominated organizations and process-oriented, informal, community grassroots

organizations.<sup>2,11</sup> This research draws attention to the importance of inviting all CBOs into public health, as was seen in the strengths of CBOs included in the document analysis and the key informant interviews. If the public health system is to benefit from collaborating with CBOs, there should be opportunities for various types of CBOs to apply—small and large, grassroots and traditional, new and old.

If there is equity in public health, then all types of organizations would be seen as valid participants, including organizations that challenge or call out the government. In particular, if collaboration with CBOs is done for equity purposes, the lack of small, grassroots-oriented organizations is problematic. The document analysis showed a lack of diversity of CBOs in the public health initiative. The key informant interviews bring more context to the data by further describing why small organizations do not participate in public health—they do not want to sacrifice their identity as mission-driven organizations and risk of not meeting the needs of the community because of the constraints and challenges of collaborating with the government funder. The challenge for the public health system is to allow CBOs to create their own spaces of participation, norms of engagement, and ways of working so that they can utilize their strengths as innovators, as people who are connected to the community, and as trusted institutions within a community.

This work also provides insight to how CBOs accept their role in the public health system. Some scholars say that CBOs needed to shift their mindset in believing the potential of cross-sector partnerships, seeing the system as the whole, and accepting that there is no playbook to cross-sector partnership.<sup>12</sup> However, it seems that this is not a barrier in this context- interviewees showed that they have the mindset to engage in partnerships for public health and non-funded RFP applicants demonstrated ability to employ public health workers and conduct health promotion. CBOs also showed their ability to act quickly to respond to changing

needs of individuals during the pandemic, and many of them were able to act faster than public health leaders, for example by conducting needs assessments and implementing a helpline in the early stages of the pandemic. This reflects what occurred across the nation—during the pandemic, more nonprofits added services rather than suspending or pausing services, even though they may have had declines in revenue and donations.<sup>13</sup> The strengths of working with CBOs are clear, and they seem ready to engage in public health work, given the space and support of the public health system.

## **5.2 Moving Towards Transformative System Change**

These findings support the acceptability of the Public Health 3.0 approach of LHDs acting as the chief health strategist and engaging in cross sector partnerships to improve health outcomes and build a stronger public health system.<sup>11</sup> The chief health strategist approach gives LHDs the role of “working with all relevant partners so that they can drive initiatives, including those that explicitly address “upstream” social determinants of health.”<sup>11</sup> This approach includes reorienting the health system towards prevention, participating and supporting community-based coalitions, and enlisting local leaders to carry out plans.

The results of these studies show little evidence of the LHDs as chief health strategist, since the LHD is not sharing power with CBOs. There must be a complete culture change within the public health system<sup>11,14,15</sup> and government-led socioeconomic reform<sup>16</sup> that enables community-led public health.<sup>4,14,16–18</sup> If power from LHDs is delegated to CBOs in communities, community engagement can be implemented for both utilitarian purposes and for social justice.<sup>17,19</sup> Collaboration could strengthen community empowerment,<sup>5,19</sup> the ownership of community interventions,<sup>20</sup> and lead to policy, systems, and environmental changes in the institutions that perpetuate health inequities.<sup>4</sup> Unfortunately, as seen in the key informant interviews, the actual practice of co-governance does not reflect the promise of being

decentralized, participatory, and transformative.<sup>5</sup> Participants voiced that collaborative programs are managed by the centrally determined regulations and longstanding norms, which does not allow space for innovation.<sup>4,5,14,16</sup> Participants also described the collaborative processes like public forums or project meetings as closed spaces that may give them voice, but not power.<sup>4,10 20,21,29,30</sup> Without open spaces of participation, there is a lost opportunity to maximize the transformative potential of cross-sector collaboration.

The result of this lack of power-sharing and trust is a siloed public health system. One example of this seen in this study is that one organization that did not apply for the funding started a resource hub for community members. One of the components of the Chicago COVID-19 Contact Tracing Corps was establishing a resource hub for Chicago residents, although it took several more months to be operational. So, although this organization's approach was innovative and reactive to community needs, this effort was a duplication of the city's resource hub that was established by the contact tracing initiative. Instead of working together with the local health department, the organization, used their own resources. This is an inefficiency in the public health system in terms of cost for implementing programs, but also takes away opportunities for CBOs to implement programs that are not yet supported by governmental funding.

These insights on the public health system are not new—the need to transform how governments do public health has been raised by scholars for decades,<sup>11,18,20–22</sup> including in the Public Health 3.0 strategy.<sup>11</sup> This study contributes to the literature by emphasizing that power-sharing is non-negotiable when it comes to public health collaboration. Public health system improvement is dependent on the government's ability to give up control so it can work in a multi-agency, multi-sectoral way that demonstrates trust.<sup>1,2,17,23</sup> The traditional public health system is fully run by the government, where systems are bureaucratic, and there is more

respect for rules and hierarchies of authority rather than voices.<sup>5,24</sup> Power imbalances will not be solved by unrestricted funding, so a commitment to building shared power is essential from public health leaders.<sup>4,5,14,25,26</sup>

### **5.2.1 Implementing Trust-Based Collaboration**

Rather than focusing on just inviting CBOs into the public health decision-making space, there must be created spaces that are inclusive to a variety of CBOs and allow for each partner to have autonomy and decision-making power. The structural processes of typical governmental collaboration limit the transformative, health justice potential of community-driven public health initiatives. Autonomy is an important factor in collaborations, and CBOs will not participate in public health efforts if they think their identities could be at stake.<sup>2,27</sup> Public health has much to learn from trust-based philanthropy,<sup>28</sup> which aims to address concerns around equity and power-sharing in grant-making.<sup>2,27,28</sup> A trust-based approach goes beyond traditional programmatic restrictions in grantmaking and places trust in organizations to use resources in ways that meet the needs of their staff, programs, and communities they serve.<sup>29,30</sup> The availability of multi-year, unrestricted funding,<sup>25</sup> simple and streamlined paperwork,<sup>25,28,29</sup> soliciting and acting on feedback, doing the homework to understand organizations' context and capacity, being transparent and responsive,<sup>28,29</sup> and offering support beyond the funding are all principles of trust-based collaboration.<sup>28</sup> These principles were seen in the key informant interviews, where participants shared that the applications for funding should be easy and reporting requirements should be reasonable and not overbearing to the point where they detract staff time from providing services to the community. Embracing trust-based collaboration will allow public health to embrace creative problem-solving and focus on collective goals.



### **5.3 Redefining Public Health Investment**

Investments in public health are more than the dollar amount—it requires a prioritization of strengthening the public health system infrastructure for community-led public health.<sup>11,18,31,32</sup> Local and federal public health funding receives a small fraction of health expenditures in the United States.<sup>33</sup> In an analysis of public health expenditures from 1960-2013, researchers found that public health expenditures made up 1.36% of total health expenditures in 1960, to 3.18% of total health expenditures in 2002, then to 2.65% in 2014.<sup>34</sup> The researchers predicted continued decline of public health expenditures. The peak of public health expenditures occurred in 2008 at \$281 per capita and then the 2008 recession resulted in a reduction on state and local public health spending.<sup>34–36</sup> Currently, it takes a disaster for leaders to realize the weaknesses in the public health system- from natural disasters like Hurricane Katrina,<sup>37–39</sup> to environmental justices like the ongoing Flint water crisis,<sup>40,41</sup> racial injustices like police violence, or a global pandemic.<sup>33,41,42</sup> We have an unstable public health infrastructure that is not ready for community-led public health.<sup>3,33–36,43</sup>

After decades of decreasing government funding to CBOs,<sup>6,34–36,44</sup> there is a renewed commitment to public health funding by the Biden administration, with a proposal that gives the Centers for Disease Control and Prevention the largest increase in their budget in nearly 20 years.<sup>45</sup> The additional funds from the CDC and other governmental entities offers technical assistance and training, but there must be change in how the money is used.<sup>18,22</sup> Even with increased funding, it would be impossible to meet the goals of Public Health 3.0 to improve and increase collaboration without transformation of the traditional government structures, funding models, and public health administration.

Public Health 3.0 calls for new sources of funding and flexible funding mechanisms and/or alternative funding models to support cross-sectoral work.<sup>11</sup> One of the strongest benefits

of cross sector alignment in public health is that it supports sustained, systems change rather than short term change.<sup>46</sup> This long-term change requires long-term funding for initiatives,<sup>29</sup> so providing organizations support over multiple years would be a worthy investment in the public health system. Long term funding it would strengthen trust between institutions,<sup>47</sup> give time for CBOs to be embedded in the community,<sup>29</sup> and increase CBO capacity to be more stable, creative, and effective.<sup>47-52</sup> Although there are alternative models for funding, they are not common enough. For example, many governmental funders limit indirect cost reimbursement, which cost reimbursement structure is very common—in the 2013 national survey of non-profits, nearly two-thirds of nonprofits reported having a cost-reimbursement structure with government grants and contracts. The cost reimbursement structure makes it difficult for CBOs' work to be sustained over time.<sup>6,51,53,54</sup> In addition, that funding should be flexible for organizations to decide how to use,<sup>29</sup> including for overhead costs—lack of funds for administrative costs hurts the infrastructure of nonprofits and makes it difficult for them to be sustainable.<sup>6,54</sup> With a flexible funding structure, CBOs will have the ability to build their internal capacity to lead long-term strategic public health efforts in the future. Another structure for funders to consider is requiring grantees that are large organizations to subcontract to smaller CBOs with less fiscal capacity. This would create structures for deep collaboration between organizations while also providing spaces for smaller CBOs to be a part of community-led public health. By considering different ways of funding CBOs, the public health system can become more stable, proactive, and equitable.

While there must be a monetary, governmental investment in public health, CBOs must also be committed to investing in public health work. CBOs need to recognize that they are an essential part of the public health system. CBOs must have a strategy and vision that fits into the system, and this will dictate their survival as an organization in the long-term.<sup>55</sup> In particular,

smaller organizations should be diverse in their scope and be open to all kinds of innovation to support the longevity of the organization.<sup>56–59</sup> Rather than being topically focused, CBOs could be focused on a specific population with a broad scope that allows them to start new program areas, given that particular grants offer training and support for implementation. Systematically, there might be a shift both internally with organizations, and externally in the broader public health system.

#### **5.4 Advisory Board Reflections**

When I set out to do this dissertation, I knew that I would benefit from the advice and insights of individuals who lead and work with community-based organizations. I incorporated these insights into my complete research process through the advisory board, composed of three professionals who work with nonprofit organizations to promote public health. Advisory board members were a part of the population I studied, as people who are on CBO boards, have worked closely with CBOs. They also understood my research, as individuals who all completed Master of Public Health degrees at my own institution and have been working in this field for decades. As individuals who were in both worlds of CBOs and public health, my advisory board members brought invaluable insights to this research. Each person brought unique experiences and strengths, and each of them shared their background during the first meeting so that the advisory board members would be able to not just have a conversation with me, but with each other. In total, I hosted three advisory board meetings: one before the study began, one after the document analysis, and one after the interviews were analyzed. We also communicated periodically between meetings to troubleshoot over email when recruitment was going slowly, for example.

I was particularly pleasantly surprised at the amount that the advisory board enhanced the quality and rigor of my research process. At each advisory board meeting, I made a point to

talk or present for at most 15 minutes and then leave the rest of the time for discussion. The insights from my advisory board members informed the refinement of my study instruments, such as the interview guide. In addition, as members of the group I was trying to recruit for interviews, the advisory board members provided feedback on recruitment materials to ensure that it would speak to my prospective participants. At the second meeting where I shared findings from the document analysis, I shared that I struggled to summarize the financial data about organizations because it was so varied. I asked my advisory board what kind of data presentation would be easy to understand and useful to draw conclusions from. They suggested grouping financial variables into bins and then looking across organizations, which is what I ultimately did to draw conclusions from. At the meeting where I shared the interview data, the advisory board members did not just verify the data—they ensured that my telling of the data makes sense and reflects the reality that they experience as professionals with decades of experience in this field. For each of the interview analyses, I shared the themes and categorizations of data that were prominent as I analyzed the data. The themes as they are operationalized in the manuscripts are a result of feedback I received that ideas I perceived as distinct are really interconnected, which contributed to the refinement of the cross-cutting themes in the thematic analysis. For the discourse analysis, one advisory board member suggested examining literature on trust-based philanthropy to inform the discussion section of the paper. During that meeting, the group talked about flexibility for organizations to be proactive, described gatekeepers in public health, and equity in decision-making. These ideas are all integrated into the discussion of the findings.

### **5.5 Limitations and Implications for Practice and Research**

Individual limitations associated with study methods are included in each chapter, but one overall limitation to this study is the case study approach. By conducting a document

analysis and interviews with CBOs specifically in Chicago that met specific criteria described in the RFP, the findings are not generalizable. However, conducting this in-depth mixed methods inquiry would not be feasible with a large-scale design that includes even CBOs who applied to different initiatives in the same city, or similar initiatives across the country. Related to the case study approach is the limitation that the study only includes 501c(3) organizations that had paid staff. While the conclusions may apply to informal volunteer organizations, the perspective of volunteer organizations or non-registered community-based organizations are not represented in the data.

There is need to understand what community led public health can look like for various types of organizations that could be considered community assets, such as block or neighborhood groups, tenant associations, church volunteer groups, youth groups, merchant associations.<sup>49</sup> Much of the time, these types of organizations are ignored in the research but still sites of innovation.<sup>60</sup> Although interviewees communicated that their community and their needs is a priority, it would also be important to engage with CBOs that are recipients of government funding and how their organizations become more like the governmental institutions, or how they resist those changes. We cannot assume that all CBOs represent the voices of the community, since working with LHDs and other government offices can raise tensions about losing community member voices. Furthermore, future research should examine how these findings are applicable to funding from various entities including (i.e. health and human services, planning departments, etc.) as well as foundations. The results of this study can support the wider participation of CBOs in collaboration, maximizing both the utilitarian and emancipatory, social justice potential of collaboration, ultimately transforming power structures and advancing health equity.

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#### SELECTED PUBLICATIONS:

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