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Community Science

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COMMUNITY PARTNERSHIPS FOR HEALTH EQUITY:
Context Matters

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1. INTRODUCTION

"Context matters" is a phrase often used by funders, grantees and evaluators when they discuss their approach to community and systems-change initiatives. However, in practice, it is rarely systematically considered and is usually addressed in retrospect as something that should be addressed in the future. Community systems-change initiatives, by definition, are intended to change their contexts and are highly impacted by the contexts in which they operate. This interplay creates a very complex and ever-changing dynamic in which history, geography, relationships, natural and human-made disasters—as well as political, economic and social conditions—all come together to affect both the process and the results of initiatives.

The purpose of this learning brief is to share insights about when and how context matters. A deep understanding of context is especially critical when working with rural communities; their context is rarely understood by philanthropy, whose grantmaking strategies often focus on the urban context. This learning brief takes a deeper look at the unique and common factors in communities that are often overlooked in philanthropic and governmental initiatives.

The information in this paper is based on the data compiled by the evaluator and staff of The Colorado Trust's Community Partnerships for Health Equity (CPHE) strategy. The strategy intended to shift decisions from the foundation to community members, to determine locally relevant issues and solutions to advance health equity. It involved more than 20 communities across the state from its conception in 2014 until its conclusion in 2022. The full story of CPHE is documented in reports available on The Colorado Trust's website, and in two previously published articles:

- Csuti, N., and Barley, G. (2016). Disrupting a foundation to put communities first in Colorado philanthropy. *The Foundation Review*, 8(4), 73-80.
- Ricci, C., Csuti, N., and Ramirez, M. (2021). The revolution within: What it really takes to partner with communities. *The Foundation Review*, 13(2), 105-118.

The communities involved in the CPHE strategy provided a fertile ground for generating insights about context, because they represent places of different sizes and locations in diverse geographic settings with distinct histories, demographics and cultures. The smallest community was a village in an agricultural area that was initially known to Indigenous peoples and then later to Hispanic and white settlers. The largest community was a city with almost 200,000 residents who can trace their roots to Indigenous, Hispanic and German-Russian ancestries. There were smaller enclave communities, such as a mobile home park with families living below the poverty level, adjacent to a more affluent neighborhood. There were also city suburbs with residents from several racial, ethnic and cultural backgrounds, including families who have been in the U.S. for generations and families who recently migrated from other parts of the world. Finally, there was a town and an unincorporated community in a ski resort area, separate in their governance and sense of community; they had been economically prosperous until petroleum prices dropped in 1998 and the main employer left the area abruptly.

2. CONTEXTUAL FACTORS THAT MATTER

Context refers to the encapsulating environments within which people live, work, play, grow and age. It includes the relationships among people in a community and those surrounding them; locality of their home and the places they frequent; history of the places; demographic composition; cultural heritage; and social, political and economic forces.

2.1 History

History is always with us. The history of a community—that is, the significant past events that shaped the political, economic and cultural conditions of the community's current state—must be understood and considered when developing a community-driven health equity strategy that strives to tackle the social determinants of health contributing to community disparities. These events could have occurred as far back as a century ago or could have occurred as recently as a year ago. What matters is the impact felt by generations of families and newcomers today, creeping into current relationships, interactions, mindsets and solutions—sometimes quietly and implicitly, and at other times brashly and disruptively. History also affects relationships among people, organizations and groups of people. Settlement and immigration patterns among ethnic, racial and economic groups can shape community contextual factors for decades or longer.

Historical displacement of Indigenous people and people of Mexican ancestry is based on long-standing biases and discriminatory practices that limit these populations' present-day access to resources and opportunities and results in collective and individual trauma that must be addressed as part of any community and systems-change strategy. The purchase of parts of Colorado by the U.S. from Mexico and the displacement of Indigenous people from their land reflect long-standing biases that continue today. Negative perceptions about people with Mexican heritage—and the nationalities and cultures of immigrants who arrived later from other parts of the world—persist even today and, whether implicit or explicit, can show up in community meetings. Some community members can feel unsafe because of the racist remarks they hear. Strategies are needed to bring community members together to learn about their communities' history, heal from historical trauma, participate in anti-oppression training, develop a sense of pride in their histories and cultures, and provide opportunities for people to have positive interactions among members of their racial and ethnic community as well as others. These strategies can sometimes be challenging to implement because of the extent of resources and expertise needed. Interventions to address historical trauma and conflict cannot be single training events but must be a long-term community-driven strategy that incorporates internal organizational reflection and accountability and integrates into other planned activities from the start.

The community's history with past funders will frame the community's initial relationship with the funder and the community's response to the funder's assistance. Funders often enter communities as if they were the first ones ever to offer support. The history of past well-intended efforts, regardless of outcomes, does not go away with just a change of players or the renaming of an initiative. Community leaders and their members live that history, and their engagement and sense of ownership will be directly tied to how outside organizations acknowledge and address past experiences with other outside helpers coming with money and ideas. Learning about past experiences, why they worked, why they did not work and how efforts can be better this time is essential.

2.2 Social, Political and Economic Forces

The effects of a declining economy on community identity, social cohesion, physical infrastructure and family incomes—all social determinants of health—must be addressed to achieve health equity outcomes. Poverty is a condition that affects many communities, especially those located in frontier and rural settings. A single industry and a single employer could have dominated the local economy for a long time (e.g., a steel mill or the petroleum industry) and attracted people from economically distressed countries. When the industry collapsed, the major employer would have left the community, leaving a sense of abandonment among those who depended on it for employment and other resources. Places that experience this situation struggle to recover from the loss and the subsequent poverty. Community members lose their connection to both the industry and employer. This impacts the community's resource base and identity, causes infrastructure to disintegrate and decreases the social cohesion among community members, both those from similar and from diverse cultural backgrounds. Communities that experience this situation may choose social cohesion as the priority social determinant of health on the path toward health equity.

Addressing the economic conditions that affect urban and rural communities is unavoidable. Economic downturns in urban areas often affect one or more limited portions of the population. In small and/or rural communities, the whole community, across different racial and ethnic groups, can experience inequity because of the greater interdependence among businesses and fewer alternative economic engines resulting in a smaller and more vulnerable economic system. As mentioned in the previous paragraph, an employer or industry's arrival or departure can cause significant, long-lasting, communitywide reverberation in small and rural communities. The disparities experienced by different racial and ethnic groups in these communities are less distinct; community leaders tend to be concerned about their whole community (e.g., Easterling & Smart, 2015).

In bigger towns in urban settings, community members in particularly segregated neighborhoods are most impacted by inequity, because of the inequitable distribution of resources across neighborhoods. These neighborhoods are more likely to be comprised of people of color, low-income families and immigrants with limited English proficiency. Consequently, the racial and ethnic disparities are more distinct. These patterns are important considerations when defining the organizing approach and tactics (e.g., neighborhood-focused, town-focused or region-focused).

Community-driven health equity strategies should include strategies that immediately address community member needs (e.g., the safety net) and support the economic growth of the people living in those communities. It is essential to provide immediate assistance to families facing economic strife as well as equitable economic development strategies that are responsive to the context of rural and urban communities.

2.3 Racial, Ethnic, Age, Gender and Political Composition of the Community and Relationships

Immigrants who have been settling into primarily white and African American communities for the past decades or more may be perceived as short-term visitors and threats to longtime residents. Community-driven health equity strategies need to address this perception and the backlash that often results from it. Immigrants can be perceived as undeserving of special accommodations (e.g., language assistance, credit and lending options) by people who feel threatened by their presence and/or who are xenophobic. Community organizations can help to shift these perceptions by coordinating projects to document the histories and cultures of the people who live there, bringing people together to celebrate their traditions and giving people the chance to have positive interactions with one another. Immigrants also may not be familiar with U.S. systems (e.g., education, housing, health) or confident in their ability to engage with the civic institutions and processes in their community. Community organizations can design and implement workshops to strengthen their understanding of how to navigate the public and private institutions and systems immigrants must interact with, and to create opportunities for immigrants to get involved in community activities, task forces and public processes. While the solutions described here are helpful, they are not likely to shift deeper racial biases, remove entrenched systemic barriers and sustain the changes. A more long-term strategy and greater resources and expertise are needed to transform narratives about immigrants and improve their access to services and other opportunities.

Relationships tend to be denser in small communities, compared to those in large suburban and urban communities, and therefore are easier to build and leverage. It is also easier to "step on toes" in these settings. A focus on healing or building on past relationships, as well as developing new ones, is especially important in smaller rural communities, where everyone knows everyone. Regardless of community size, knowledge about where power is concentrated, a commitment to collective action and skills in community mobilization and organizing are pivotal for success. The more people there are in a community, the more relationships need to be built, but regardless of community size and the number of relationships, knowledge about where power is concentrated is key to being able to influence decisions to change the social determinants of health. In small communities, the people and institutions with power are easier to discern, because the power lies in a few individuals (including founding families) and everyone knows who they are.

While the target of change—that is, the institutions or systems that are limiting access to resources and opportunities for historically disadvantaged populations—may be more apparent in relatively small communities, it also is more challenging to organize against the institution or system because the entities may be led by someone who is a neighbor, parent of a child's friends or person you stop to chat with at the store. In relatively larger communities, the people and institutions with power are less likely to be people with whom residents have direct or indirect ties and more likely to be an elected official, such as a school superintendent or county commissioner. This does not make it easier or harder for community engagement and community organizing in rural communities; it just means that the community capacity to organize operates differently. Communities that understand this dynamic might go out of their way to build relationships with elected officials, leverage the positions of community team members in their workplace (e.g., in a local department of health) or run candidates for election to ensure that the voices of those most affected by health disparities are represented.

The demographic composition of a community—shaped in large part by the aforementioned historical forces—affects relationships and especially trust among different groups of people. Funders need to be prepared to address head-on the conflicts between longtime residents and immigrants (documented and undocumented); between younger and older community members; among different racial, ethnic and cultural groups; among people with different gender and sexual identities; and among people with different political affiliations. For example, in communities with relatively large populations of undocumented immigrants or community members with limited English proficiency, community mobilization and engagement can be challenging because of fear of deportation or limited capacity for civic engagement. There are additional challenges for those with undocumented status in being compensated monetarily for participation, as this poses legal challenges for funders. Trusted outreach workers and organizers can be engaged to help keep these community members engaged in the community change process. People who have similar lived experiences or who are able to communicate with community members who do not speak English need to be recruited and supported to build relationships and trust.

Intergroup tensions—whether among Black and white people, Brown and Black people, immigrant and refugee groups or even people with different political affiliations—exist in communities and need to be intentionally addressed from the very beginning and throughout the implementation of the strategy. The first step for funders is to openly recognize such tensions and to incorporate conflict transformation and restorative justice practices into their strategy. An additional proven approach involves finding common issues facing these communities and supporting their collaboration on them across groups. The use of skilled facilitators and organizers who are not staff of the funder is critical for the success of these approaches.

The impact of trauma on the individual level is compounded by community-level trauma and adversity. Across historically marginalized communities, some level of community trauma is always present. Trauma could be felt by immigrants because of experiences in their countries of origin and prejudices about them, by African Americans or Hispanic and Latinx people who experience racism in their daily lives, by Indigenous people who were displaced from their land and by all community members—regardless of their racial, ethnic and cultural backgrounds—due to poverty. Violence, substance use and other factors disproportionally affecting these communities add to the individual and collective experience of trauma. Trauma is costly to people who experience it and a widespread public health problem that can impact the success of health equity efforts (Substance Abuse and Mental Health Services Administration, 2014). Funders can bring resources and expertise to help organizations implement trauma-informed practices and facilitate community-healing processes where they are needed.

2.4 Locality

Location matters a lot. The geography of communities and their size can influence relationship-building, availability of supportive resources and social networks. When social networks are strong, so is social capital, which is pivotal for access to resources and opportunities. Social capital also affects a community's capacity to act collectively (Popay et al., 2020). Funders should tailor strategies appropriately to address the strengths and challenges facing small, midsize and large communities or between frontier, rural, suburban and urban settings—one size does not fit all.

Small rural communities often have "founding families" who "take care" of the community, given their economic power and social prominence. This dynamic needs to be addressed when organizing for building community power, especially among those who have been historically marginalized. Where they exist, these founding families have an obvious vested interest in maintaining the status quo. That affects relationship- and trust-building and makes it challenging to implement community organizing tactics that can be perceived as confrontational. Communities that are relatively small may be led by families who have lived there for generations, dating back to when the towns were founded. Within the CPHE strategy on which this learning brief is based, there were participating communities in which prominent local families held all the economic and political power. In these places, family members may hold grudges that started generations ago. Community organizations may struggle to organize against institutions to which these families have ties because it means opposing their neighbors and the leaders of governing entities in the community, from the local council to the school board. Additionally, multigenerational differences between family members can play out if they are part of a community team or funding effort.

It is important to learn the power structures in these communities and engage the families and individuals with power from the start. Members of these founding families may have their own nonprofits or strong influence over the nonprofits in the community. These factors need to be considered for community organizing strategies, especially in small communities, which revolve around relationships and where residents may struggle to use organizing tactics that focus on confronting founding families. In these cases, context needs to be taken into account and organizing approaches adjusted accordingly.

Larger communities in a region often pull resources and attention away from the smaller and geographically remote communities near them, leaving the latter with limited resources and capacity. Consequently, a regional approach may work better. Local government often prioritizes larger communities at the expense of small communities, because larger communities typically generate more revenue (via businesses and taxes). Community members in relatively small and geographically isolated or segregated communities may feel "forgotten," "left behind" or "swallowed up" by larger neighboring towns. Compared to the nearby larger towns or neighborhoods, they have fewer recreational, health and economic resources. They also have a smaller pool of people to draw from to coordinate and support community-driven health equity initiatives, including translators, interpreters, survey administrators and community organizers. In contrast, the large towns or neighborhoods have more infrastructure for communication, transportation and service delivery.

Geographic distance, especially from larger cities, is another major contextual factor that needs to be planned for and addressed early in the implementation of a community-driven health equity strategy. This geographic disparity leads to differences in access to resources, employment opportunities, social and health care services, broadband internet access and other critical factors. Members of small communities often have to travel to neighboring and resource-rich towns for employment, health care, recreational, financial and other social needs (e.g., postsecondary education, job training, grocery stores that sell healthy and fresh produce). Traveling for services leaves little time for and interest in building community and fostering a sense of community pride. Also, the lack of broadband internet access in so many rural communities and low-income urban neighborhoods makes it difficult to access services

virtually (e.g., telemedicine, professional development courses). A common, effective solution that some small communities can implement is to bring resources to their communities—including mobile clinics, mobile food markets and broadband access—and to restore and repair existing facilities. A regional approach for support and capacity building may work better when supporting more geographically isolated rural communities for these reasons (Easterling & Smart, 2015).

Nonprofit and community power-building infrastructures (or ecosystems) tend to be smaller and more under-resourced in rural communities than in suburban and urban places, and this needs to be addressed in a community-driven health equity strategy. The more isolated rural communities are, the less access they have to capacity-building and technical assistance consultants, information about what is happening statewide and in other communities, and organizations with which they could collaborate. In addition, the organizations in these communities have to provide for emergency quality-of-life needs as these needs emerge in the community (e.g., during a pandemic, a natural disaster, an economic downturn) and to address issues that are of immediate priority for community members (e.g., summer programs for youth, improvement or renovation of parks), as well as tackle larger, long-term community and systems changes. It is most important in these contexts that organizations are effective in engaging community members and steadfast in their commitment to deliver services and support.

Community-driven health equity strategies should plan to provide a regional approach or support the creation of an ecosystem to build the capacity of initiatives in rural areas if one does not yet exist, with the intention to rapidly respond to emerging and existing needs.

A sense of community is difficult to cultivate and sustain in transient towns (e.g., resort towns), and thus, such efforts require intentionality in developing shared leadership and a process for knowledge development and transfer on how to address this contextual issue. This intentionality is necessary in all community contexts but is especially critical in places where leaders and members might be transitioning in and out of a team or community effort to pursue opportunities that are more abundant elsewhere. People pass through communities that have historically been transient towns for jobs and affordable housing. The transient nature of these towns is also often associated with being small and unincorporated, and lacking in infrastructure and opportunities, or it could be associated with being a place where it is common to distrust outsiders. In these cases, engaging and retaining community participation is difficult. Technical assistance for this sort of community might intentionally focus on a model of shared leadership on the community team; a system for documenting and archiving information; and an efficient onboarding process for new community members—efforts that all work toward ensuring that the community does not lose the specialized knowledge held by community members to inform how actions can be mobilized (Edwards & McCarthy, 2004).

Funder staff need to be physically, mentally and emotionally accessible and available to the communities with whom they are working to build relationships, especially if the funder is interested in being more than a grantmaker that monitors progress from a distance. Virtual meetings are not enough for staff to develop a trusting and active relationship with grantees

and their communities. Whether working with urban or rural communities, sharing meals and meaningful times in person are invaluable for developing the type of relationships that can grow and contribute to addressing systemic issues. Shifts in communication, relationships and, especially, trust occur when funder staff conduct annual or semiannual site visits, when they meet, listen to and interact with various levels and types of local stakeholders.

Grantees and community leaders in small and/or remote communities often raise concerns that funder staff "just do not get" what is going on in their community. It is not enough to learn about grantee communities at the beginning; this learning needs to be cultivated constantly and deepened through continuous relationship-building. Community and organizational leaders and staff change, conditions change and the funder's staff change, so continuous relationship-building with grantees and community members needs constant maintenance. It is a sizable additional responsibility for staff that will result in more genuine relationships and make a major difference to those working "on the ground" and taking on critical and sometimes overwhelming issues with little other support.

3. CONCLUSION

There are several actions and principles that can be derived from the analysis of when and how context matters in community-driven health equity strategies:

1. **Do your homework.** A deep analysis of contextual factors is a critical first step and should be conducted on a community-by-community basis. One size or approach does not fit all. Identifying the historical, geographic and community composition—including intergroup relations—is necessary. Contextual issues are always present, affect community-driven health equity strategies and are also affected by them.

2. **Act on what you learn from the beginning.** Acknowledging these contextual factors is not enough. Clear action on these issues needs to be taken with consent and support from community members. If that is not possible, you should state upfront what is and is not within your abilities and purview, or state other barriers you face. Use what you have learned about opportunities and challenges posed by the history, geography, economic conditions, demographics and conflicts within that community explicitly and transparently from the very beginning. Community Science has found that funders who overlook or ignore these issues find that the issues resurface and undermine efforts. Tensions between ethnic groups, community experiences with the last funder and their participation (successful or not) in community-driven initiatives will manifest at some time during the strategy implementation and can be highly disruptive, including delaying or abandoning a local effort usually when it is too late to address.

3. **Keep on learning.** Context always matters, especially when regarding community-driven health equity strategies. Reflecting on these contextual factors annually, if not more frequently, is critical. Evaluations of community-driven health equity efforts should not see context as a static backdrop to the work, but as a dynamic and influential component that affects outcomes and is affected by a well-thought-out and implemented strategy.

4. **Use a different approach for rural, geographically isolated communities.** There are specific contextual factors at play when working in rural, isolated or tribal communities, including access to resources that are geographically available to communities in or near major urban areas and local power dynamics. In these cases, approaches must be adapted. For example, a regional focus can be more effective when small, rural, remote or unincorporated towns are part of the mix of communities included in the strategy (Hopkins & Ferris, 2015).

5. **Effectively planning for and addressing community contextual factors takes time.** Funders must recognize and set aside time to both build understanding of community context and allow for building relationships in community. Community change efforts, community organizing and systems-change work take significant time and energy investment as well as a shift in relationship between funder and community members. This commitment and investment should be intentional and planned for up front.

Context does matter. For funders wishing to deepen engagement with local communities and support community change efforts, understanding the above elements of community context is necessary for creating effective and impactful community strategies. It is our hope that the insights gleaned from the 8-year CPHE strategy contained in this learning brief help to support and guide funders in effectively preparing for their own community efforts and to better act on and operationalize the ways in which "context matters."

4. ENDNOTES

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