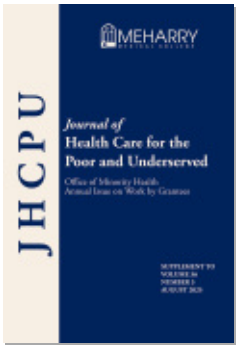
Transforming a Regional Initiative by Building Community Power to Advance Health Equity



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Transforming a Regional Initiative by Building Community Power to Advance Health Equity

Blanca Meléndrez, MA
Shana Wright, MPH
Adriana M. Bearse, MS
Lan T. Nguyễn, PhD, MURP
Jaclyn Resnick, MPH
Eric Hekler, PhD
Delfina Alvarez
Maribel Arias
David Barber-Dunham
Earl Felisme
Judit Garcia
Tana Lepule
Rocina Lizarraga
Regina Moreno
Naomi Billups
Katie Gordon
Luis Galvan, MPH
Liliana Osorio, MPH
Bill Oswald, PhD
Lexie Palacio, MA
Shaila Serpas, MD, MPH

Summary: This report describes the transformation of a San Diego County collective impact initiative to center community voices through the co-creation of a community council to address childhood obesity. We present seven suggested recommendations for others interested in forming a community council within a collective impact effort and highlight challenges and future directions.

BLANCA MELÉNDREZ, SHANA WRIGHT, ADRIANA M. BEARSE, LAN T. NGUYỄN, JACLYN RESNICK, *and* ***ERIC HEKLER*** *are affiliated with the University of California San Diego.* ***DELFINA ALVAREZ, MARIBEL ARIAS, DAVID BARBER-DUNHAM, EARL FELISME, JUDIT GARCIA, TANA LEPULE, ROCINA LIZARRAGA,*** *and* ***REGINA MORENO*** *are affiliated with the Founding Community Council.* ***NAOMI BILLUPS*** *and* ***KATIE GORDON*** *are affiliated with the County of San Diego.* ***LUIS GALVAN*** *and* ***LILIANA OSORIO*** *were formerly affiliated with the UC San Diego Center for Community Health.* ***BILL OSWALD, LEXIE PALACIO,*** *and* ***SHAILA SERPAS*** *are affiliated with the San Diego County Childhood Obesity Initiative Key Partners. Please address all correspondence to: Blanca Melendréz, UC San Diego Center for Community Health, 9452 Medical Ctr Dr, La Jolla, CA, 92037; Phone: (619) 778-0139; Email: bmelendrez@health.ucsd.edu.*

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Health equity is " . . . the state in which everyone has a fair and just opportunity to attain their highest level of health."[1[p.1]] Advancing health equity in pressing public health issues such as childhood obesity requires individuals and community members experiencing health inequities as core co-leaders of any effort meant to serve them.[2] Despite this, established collective impact initiatives—defined as collaborative efforts where partners align their actions to achieve shared goals—may struggle to effectively include community members as co-leaders.[3] Our purpose is to provide a case report on how, within a collective impact initiative focused on childhood obesity prevention, we transitioned from a managerial leadership to a movement-building model that centers the priorities and goals of communities.[4] We propose seven recommendations for others interested in advancing a similar transition and highlight limitations, challenges, and future directions.

Background

Our work fits within collective impact efforts, which aim to address complex problems via cross-sector collaboration.[5] Early collective impact efforts—such as Shape up Somerville, a citywide effort to address obesity in elementary schools—formed organically across regions with varied implementation methods.[4,5] The San Diego County (SDC) Childhood Obesity Initiative (Initiative) was one of these pioneering collective impact efforts. It sought to create a long-term, cross-sector solution to the growing childhood obesity epidemic in SDC, bringing together government, community, schools, health care, and business partners under a unified agenda.

Region. San Diego County (SDC) is one of the nation's most diverse regions. The population is 35% Hispanic, 20% are foreign-born, and 35% speak a language other than English.[6] San Diego County is home to more American Indian reservations than any other U.S. county[7] and has a growing refugee population.[8] While income levels vary, 10% of residents live in poverty with higher rates among Black and Hispanic communities.[9] In 2019–2020, 34.1% of SDC children and 28.5% of teens were overweight or obese with higher rates among low-income families and Hispanic children.[10]

History. Formed in 2006 by the County Board of Supervisors, the Initiative aimed to ensure effective implementation of the *Call to Action: San Diego County Childhood Obesity Action Plan*.[11] This effort built on the work of the Coalition on Children and Weight San Diego, with coordination support from a local non-profit, Community Health Improvement Partners (CHIP). A steering committee, including County staff and experts from health care, nutrition, and physical activity, guided the process. From 2006 to 2019, the Initiative operated according to the core principles (indicated by italics) of a collective impact approach, even before the term was formally coined in 2011: CHIP provided *backbone* support to the Initiative; a multi-sector steering committee led a *common agenda* and *mutually reinforcing activities*; the Initiative used *shared measurement systems* to examine and track community data; ongoing, *continuous*

communication between partners ensured alignment; and an executive leadership team and leadership council provided a *managerial approach to leadership*.[4,5] The Initiative's early work focused on implementing policy, systems, and environmental changes to address childhood obesity, such as improving school wellness policies and expanding access to safe streets, by aligning the efforts of multi-sector partners. Initiative members included professionals working across seven sectors (business, community, early childhood, government, health care, media, and schools) through domain-specific working groups, each chaired by expert partners. Backbone support provided by CHIP included facilitation of meetings, strategic planning, resource coordination, communication across sectors, and tracking progress toward shared goals—core functions outlined in the action plan. While the Initiative included community engagement strategies, such as Resident Leadership Academies,[12] it lacked representation from affected communities in its Executive Leadership Team, Leadership Council, and decision-making processes.

With a shift towards emphasizing health equity within the collective impact approach, a movement-building leadership paradigm emerged,[4,12] with a refined collective impact definition of "a network of community members, organizations, and institutions that advance equity by learning together, aligning, and integrating their actions to achieve population and systems-level change."[13[p.1]] In February 2020 (discussed below), the Initiative started the transformation from being a managerial-led to a movement-building initiative.

Timeline

In February 2020, community leaders were invited for the first time to participate in the Initiative's strategic planning retreat. Retreat participants included 46 Initiative members representing public/private organizations and six community leaders from one community-based organization (CBO). Retreat participants identified *changing the culture and work of the Initiative to include more community voice and authority* as a recommendation. After spending 2020 responding to the COVID-19 pandemic, the Initiative returned to this recommendation at the February 2021 retreat. Attendees included community leaders from seven CBOs and the Initiative Leadership Council. Supported by the SDC Board of Supervisors January 2021 declaration of racism as a public health crisis,[14] the retreat culminated with the shared understanding that "structural racism is a foundational cause of obesity . . . [and] . . . integrating racial equity into the Initiative required a multipronged approach of antiracism work and inclusivity to the structure, function, and collaboration of the Initiative."[11[p.20]]

Following the retreat, the Initiative's Community Domain, a working group comprising representatives from trusted community, faith, youth, grassroots, and public organizations with longstanding relationships across SDC, was tasked with exploring approaches to centering community voice in the Initiative. In May 2021, the Community Domain proposed the *community council* model, which is an approach to empower communities through active participation in decision-making processes, ensuring representation and equitable influence on policies and actions that affect them.[15,16] The Community Domain developed and implemented an action plan over 12 months. To

start, the Community Domain and broader Initiative partners nominated community leaders from grassroots organizations and CBOs with deep, trusted relationships in the community to participate in the Initiative's Community Council (CC) development process. From October to December 2021, a CBO partner facilitated four three-hour sessions with 24 diverse community leaders speaking Arabic, English, Somali, and Spanish to co-develop a structure and compensation model for the CC. Fifteen of these leaders met from January to June 2022. They participated in the Initiative's annual retreat, provided input on priorities, engaged in policy agenda discussions, and contributed to five visioning sessions defining the CC's roles, responsibilities, and bylaws. The CC was officially formed in July 2022 and integrated into the Initiative structure in May 2023 (see Figure 1 for timeline).

Structure of the Community Council (CC)

The goal of the CC is to shift policy decision-making from the prior managerial approach to a co-leadership structure in which the community defines the priorities and goals for movement-building work. This structural change is visualized in Figure 2, which highlights how, in the managerial leadership approach (left), there was no CC and, instead, priorities came from the Executive Leadership Team of the Initiative. The Executive Leadership Team was formed at the inception of the initiative to provide high-level strategic and policy guidance. Team members were invited based on their institutional roles and decision-making authority across the Initiative's seven domains and included the County public health officer, an early childhood executive director, a family physician, and a Board of Supervisors policy advisor. In the revised model (right), the CC is recognized as the central group for defining the priorities and for ensuring community voice, strengths, and assets are centered. Institutional leaders play critical co-leadership roles. The Domain Council represents the co-leaders of each sector-based domain (e.g., government, early childhood, health care, schools, community), a structure used since the Initiative's inception to organize aligned activities and policy goals across the Initiative. The Leadership Council includes institutional leaders who, collectively, have wide-ranging institutional knowledge and resources. Leadership Council members were identified through their active participation and commitment to the Initiative. Together, this leadership structure supports movement building via: 1) centering the CC's priorities, goals, and knowledge of the real-world assets and strengths of communities experiencing health inequities as guides for the Initiative; 2) cross-sector leadership and drive for devising viable action plans aligned to community priorities via the Domain Council; and 3) strategic and political knowledge and resources that can guide strategic timing and prioritization of action plans, to increase the likelihood of demonstrable change via the Leadership Council.

CC governance. Tri-chairs, nominated and elected by CC members, govern the CC. While there are no formal criteria, CC members are encouraged to nominate individuals they believe will be strong leaders while encouraging diversity in background and perspective among tri-chairs. The tri-chairs participate in the Initiative's Leadership Council; guide the CC work; facilitate monthly CC meetings; and engage new, existing,

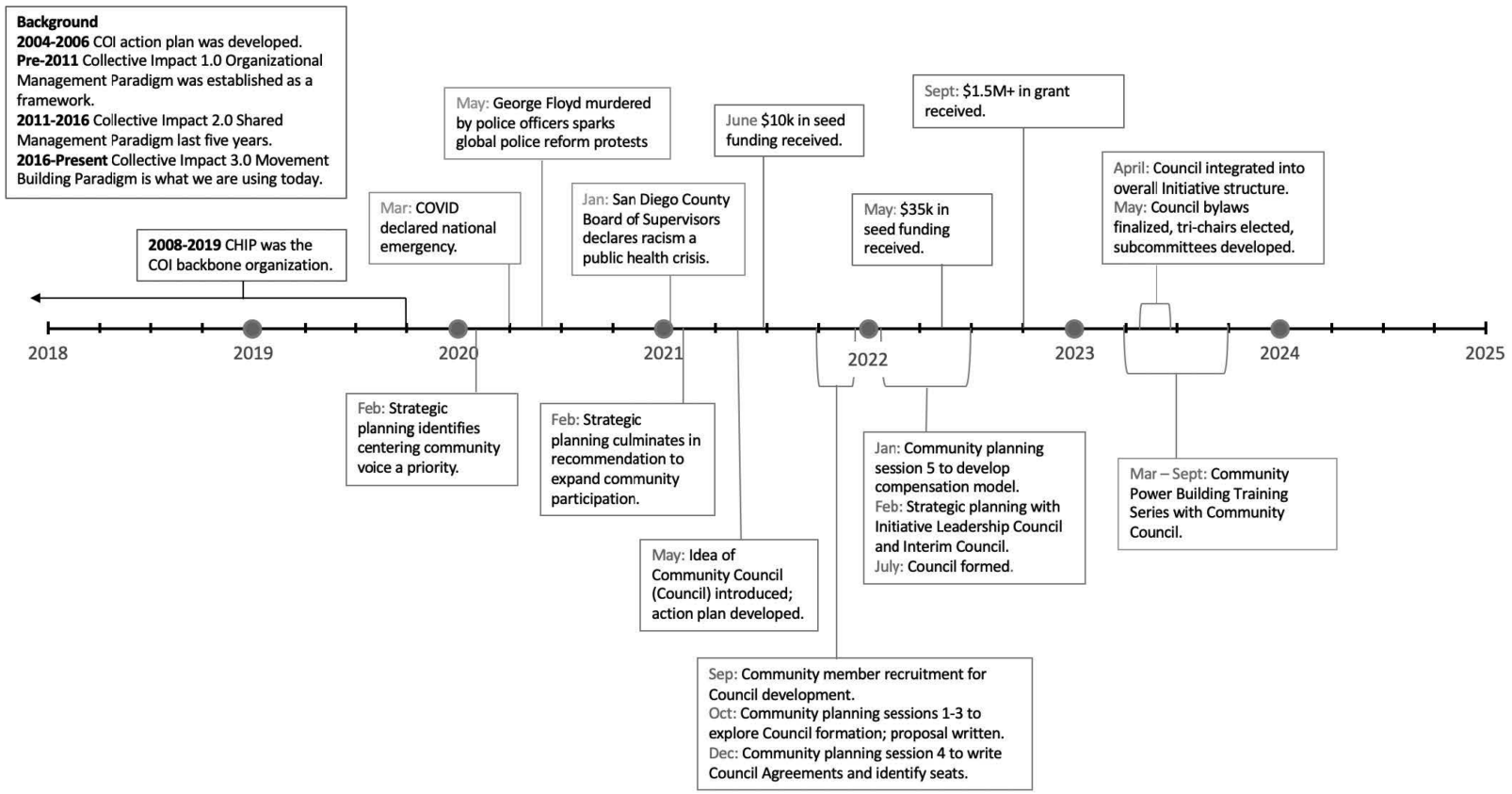
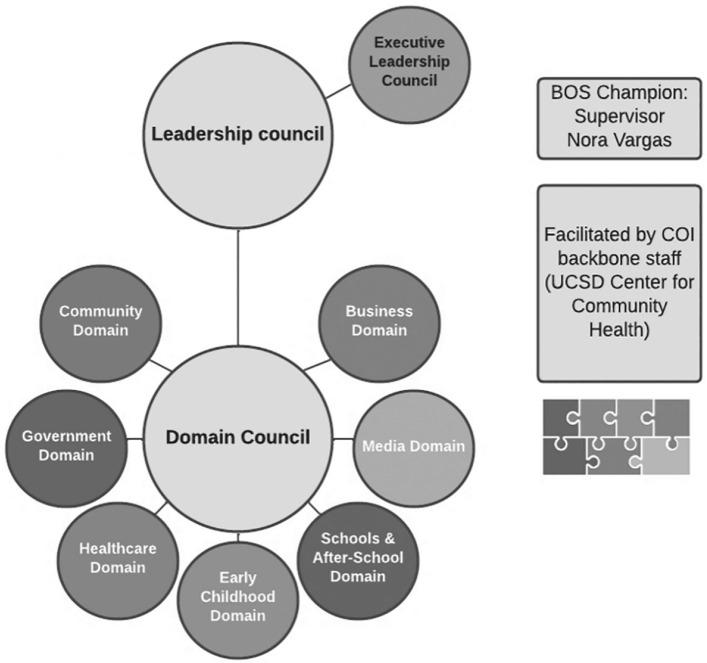


Figure 1. Community council formation timeline (separate PDF).



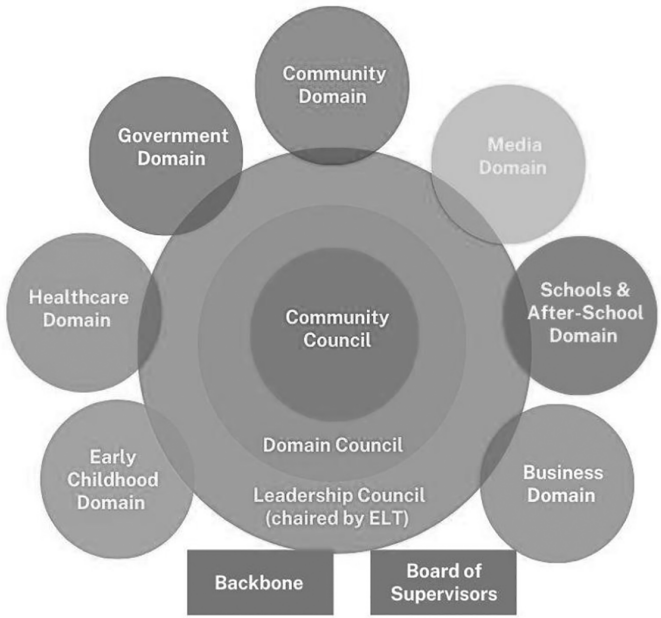


Figure 2. From management to movement-building leadership.

and potential members. Tri-chairs serve a two-year term, with staggered start and end dates to promote continuity and allow for peer mentorship and knowledge transfer between outgoing and incoming tri-chairs.

CC roles. Community Council members: (1) share community knowledge with and educate other Initiative members about different traditions and ways of knowing to inform research and practice; (2) communicate community concerns and perspectives with the broader Initiative membership to shape the Initiative's policy agenda; and (3) inform and engage the community in Initiative activities.

CC membership. Initially, the Initiative's Community Domain identified CC members. Community Domain partners leveraged their existing connections to community leaders—many of whom had expressed interest in centering community voice in health equity efforts—to nominate individuals with lived experience, leadership potential, and a commitment to advancing community-driven change. Over time, CC members recruited and nominated additional leaders, ensuring a broad and representative selection process. Today, any Initiative member can propose new community members to the CC, with democratic processes used to advance proposed members.

The CC includes up to 15 trusted multicultural and multiethnic community leaders who bring lived experiences grounded in the community's perspective. The CC aims to engage diverse community members from a range of identities and lived experiences, such as educational attainment, socioeconomic status, (dis)ability, and geographic region. This is a viable pathway to counteract structural forms of marginalization, oppression, exploitation, and/or harm that can become entrenched.

Evaluation

The evaluation built on the Initiative's longstanding commitment to shared measurement, one of the core conditions of collective impact. Evaluation methods were co-developed to align with community priorities. We employed a Rapid-Cycle Evaluation approach[17] to support iterative evaluation and improvement (approved 1/31/2024, IRB #809044). Specifically, we used an iterative design process, as used in human-centered design, as our structure and model for evaluation development and refinement.[18] The intention behind this approach is to articulate both potential issues that must be addressed and corresponding hypotheses on how to address them. Based on this, we identified surveys and focus group data collection with CC members, and feedback gathered through meetings and other communications with CC members, the Initiative Domain and Leadership Councils, as the most efficient methods to collect evaluation data.

We designed and implemented a Qualtrics survey and a virtual focus group conducted via Zoom to examine the degree to which the intended goal of shifting power and decision-making to the CC was being experienced by the CC. The survey included questions about CC member backgrounds, community engagement, capacity building, multi-sector relationships and inclusivity, changes in decision-making authority, and centering the role of the CC within the Initiative. The survey was launched and completed in November 2023 and asked about time on the CC from July 2022 to October 2023. Following the survey, we conducted a focus group (Nov. 14, 2023) with

CC members to explore how CC members experiences within the Initiative changed over time. Finally, we conducted a Ripple Effects Mapping evaluation[19] to evaluate perceived impact of the CC on community policy and systems change. Data collection and refinement were done iteratively to enable the group to use the data to directly improve the targeted system or process, in this case the CC.

The 82-question survey was completed by 15 CC members (88% response rate). Survey results (Table 1) generally highlighted self-reported increases in community engagement and capacity building (knowledge, self-efficacy). Shifts in perceived decision-making authority along the Spectrum of Community Engagement[15] were more complex, with some perceiving a stronger shift to a *collaborative* role and others perceiving less *leadership* abilities from when they first joined the CC to the time of the survey (23% to 46% and 23% to 15% respectively). When interpreted in combination with qualitative feedback collected through focus groups and communications, the slight decline in the number of CC survey respondents reporting they felt they had full decision-making authority may suggest power-sharing dynamics are not uniform across the CC due to variability in individual CC members levels of involvement; a growing awareness of power-*sharing* rather than reduced influence; or may be due to the small sample size. Survey respondents also reported strengthened multi-sector relationships within the Initiative, including feeling respected by Initiative co-leadership. One survey respondent said, *"I see everyone is much more engaged, everyone is eager to chime in, to get work done. It is refreshing and exciting."* Another respondent shared, *"The community council has definitely strengthened* [our] *voice and that can be seen through the decision-making within* [the] *Initiative."*

A 2024 Ripple Effects Mapping evaluation conducted with Initiative councils (i.e., Community, Domain, and Leadership) highlights the CC's impact on community-led advocacy to create positive change. For example, the CC's leadership in conducting and presenting findings from 13 community-led walk audits resulted in the incorporation of their recommendations into the San Diego Association of Governments' 2024 Regional Vision Zero Action Plan.[20] The CC contributed to a successful grant proposal to the American Heart Association, where CC members serve as co-principal investigators to advance community-driven research aligned with a community-identified priority area of food justice, supporting the Initiative's overarching goal of increasing access to healthy food as a key strategy to address childhood obesity.

Recommendations

Building on our community-led transformation principles,[21] we identified seven recommendations for forming a community council:

(1) Focus on authentic, reciprocal relationships. Establishing, earning, and maintaining trust takes time but is critical to shared power and co-development of priorities and action plans, which require authentic, mutually beneficial relationships. Example strategies include consistent, monthly meetings, tri-chair planning meetings, in-person convenings, and one-on-one check-ins with dedicated support staff.

Table 1.

COMMUNITY COUNCIL MEMBER SELF-REPORTED IMPACT; PRELIMINARY ANALYSIS

Question Type	Question	Response Options (Code)	Result (mean score or %)
Community Engagement	During your time in the CC, how has the engagement level *of the CC as a whole* changed over time? (n=15)	Increased significantly (5); Increased somewhat (4); No change (3); Decreased somewhat (2); Decreased significantly (1)	4.3
Capacity Building	**Please rate how much you agree or disagree with each of the following statements.** As a result of my time in the CC I have . . . (n=14)	Strongly disagree (1); Disagree (2); Neither Agree nor Disagree (3); Agree (4); Strongly agree (5)	
	Been provided with opportunities to develop as a leader.		4.5
	Increased my knowledge of topics relevant to my work as a community leader.		4.6
	Gained skills relevant to my work as a community leader.		4.4
	Increased my confidence in my ability to apply knowledge and skills as a community leader.		4.4

(*continued on p. 33*)

Table 1. (*continued*)

Question Type	Question	Response Options (Code)	Result (mean score or %)	
			When you first joined . . .	**Currently . . .**
Changes in Decision-Making Authority	***When you first joined the CC [Currently]*, what role do you think the CC played informing policy/advocacy decision making within the COI?** Please select the response that you feel best fits. (n=13)	The CC *informed/informs* the Initiative, providing community information and perspective that is used in decision-making processes.	8%	8%
		The CC *consulted/consults* with the Initiative, offering feedback on decisions made by the Initiative.	15%	0%
		The CC was/is *involved* in Initiative decision-making, ensuring community needs considered in Initiative planning.	31%	23%
		The CC *collaborated/collaborates* with the Initiative, participating in every aspect of the Initiative decision-making.	15%	46%
		The CC *led/leads* Initiative decision-making processes, having decision-making authority and receiving support from the Initiative.	23%	15%
		I am not sure/don't know	8%	8%

Note
Data source: Community Council Annual Survey 2023

(2) **Foster bi-directional communication and collaboration**. Create communication structures that support dialogue that fit into community members' norms. Example strategies include CC members participating in subcommittees aligned with Initiative domains to ensure communication and collaboration between CC members and institutional partners.
(3) **Co-develop a compensation package that recognizes the expertise and time contributed by community members**. Community Council members should receive compensation (including transportation support, if needed) for the time they spend at meetings and trainings both in recognition of their lived expertise and, unlike institutional partners, the fact that this work is not compensated via their "day job."
(4) **Commit towards continuous improvement of accessibility and inclusion**. Recognizing existing constraints, commit to iteratively remove barriers to participation. Example strategies include flexible meeting schedules, transportation support, and adherence to National Culturally and Linguistically Appropriate Services (CLAS) standards to advance inclusivity aligned with the most pressing accessibility issues identified by collective impact members.[22]
(5) **Focus on skills-building among council members**. Provide training to CC members to equip them with skills to address systemic issues through collective impact. Example strategies include having CC members engage in advocacy workshops, research and community-building trainings, and collective impact conferences.
(6) **Leverage multi-source funding**. Adopt diverse funding models, combining public, private, and philanthropic sources, to manage current funding constraints (see acknowledgments for sources of funding used to support the Initiative's CC). Diverse funding sources are essential to support the other recommendations such as staff time, skill building, and additional costs for interpretation and translation.
(7) **Invest in infrastructure to advance reliability**. In line with Haines' definition of trust as requiring intentions + capacities + reliability,[23] first align on shared priorities and then identify the capacities and resources needed to reliably enact those capacities. Advancing reliability requires infrastructure, such as sufficient staffing, time, and capacity to identify and repair ruptures in relationships between individuals and communities.

Limitations

This case study is rooted in San Diego County, which shapes its strategies and outcomes. The approaches may not be appropriate elsewhere. While the CC made strides in fostering diversity and inclusivity, representativeness is a perennial challenge. It is important to note that the previous leadership structure primarily comprised representatives from public and private organizations, rather than individuals with lived experience. In contrast, the current CC includes members with direct ties to the communities served including 34% Hispanic/Latino, 12% Asian/Pacific Islander, 5% Black/African

American, and 4% representing two or more races, prioritizing community voice over institutional representation. Language and cultural barriers persist as we are only able to support monolingual Spanish speakers in a diverse county needing more linguistic support. A critical limitation is reliance on grant funding, including federal, state, and county grants, to initiate and sustain the CC. Grant funding can be unstable and time-limited, often subject to shifts in political priorities, economic conditions, or changes in priority funding areas, which may pose challenges to the long-term sustainability and scalability of the CC.

Future Directions

We are actively pursuing a diversified funding strategy that includes public, private, and philanthropic support to enable long-term stability. We seek to make progress without over-promising and under-delivering. Future efforts will focus on expanding the CC's influence to refine the movement-building co-leadership approach. This includes exploring partnerships with new sectors to address community priorities (e.g., housing was a high priority area but beyond the scope of the Initiative). We also aim to deepen our capacity to understand historical, present, and emerging forms of marginalization, oppression, exploitation, or harm, specifically in the context of childhood obesity as it relates to food, health, and neighborhood justice. We seek to minimize their impacts to advance health equity by being responsive to community needs and ensuring that our efforts reflect the perspectives and priorities of groups that have been historically excluded.

Conclusion

This report from the field describes the transformation of a collective impact initiative from a managerial to a movement-building governance. This translates to a co-leadership structure that includes a) community members defining key priorities, b) cross-sector leaders committed to developing and implementing action plans aligned with community priorities, and c) institutional leaders capable of aligning action plans with strategically viable moments. This is a community-driven approach for re-imagining approaches to democratic norms and shared governance across a region that has the potential to make progress on advancing health equity.

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