From Engagement to Action: Assessing Community Readiness for Disparities Mobilization

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ABSTRACT
In an effort to engage communities across the state of Massachusetts in tackling health disparities, Critical MASS (CM), in partnership with local researchers piloted a readiness assessment to identify community assets, perceptions of disparities, and interest in partnership. The research process was used to facilitate the development of partnerships between outside organizers, researchers, and community stakeholders. Partnership outcomes included a disparities conference aimed at bringing attention to concerns in the community, and a grant submission aimed at addressing community identified disparities. Despite the successes the partnership faced challenges. Logistics and limited resources hindered partner efforts to sustain the relationship. This paper describes the readiness assessment methodology, results, community-level outcomes, and lessons learned.

Keywords: Community readiness, disparities mobilization, partnership
INTRODUCTION

Community engagement is a critical component in working with populations impacted by disparities in health and health care. Working with community has proven effective in developing strategies to tackle health disparities, by providing public health practitioners, policy makers, researchers, and community organizers with data to inform the development of evidence-based efforts to address disparities (Minkler, Vasquez, Chang, & Miller, 2008; Wallerstein & Duran, 2006). If research is to inform policy and programmatic changes, it is essential to understand community public health needs and priorities, and tailor efforts accordingly. For such efforts to be successful, it is important to meet the community where they are, and to determine community readiness to engage in efforts to address health. This requires understanding civic and local organizational capacity, motivation, and preparedness for health disparities-related action, as well as a community’s past and current experience with such efforts.

We present findings from a community engaged research project conducted to foster the development of a regional coalition to address health disparities in Holyoke, Massachusetts. The research was commissioned by Critical Mass (CM) a public-private partnership committed to eliminating health disparities in Massachusetts. The goal of this project was to identify opportunities and vehicles for CM to provide support for the Holyoke community in new and existing health disparities-related efforts. As such, the research consisted of a community readiness assessment which included an examination of local assets.

The approach is novel because the research process was used to facilitate the development of partnerships among organizers, researchers, and community stakeholders, as opposed to initiating the research with established partnerships in place. Despite successes the partnership faced challenges, as the distance between the communities of Holyoke and Boston, where CM is headquartered, and limited resources hindered CM efforts to sustain the relationship. This paper describes the readiness assessment methodology, results, community level outcomes, and lessons learned, including barriers to success.

BACKGROUND

Health disparities are differences in health status, health care access and treatment experiences that are unnecessary, avoidable, unfair and unjust (Laveist, 2005; Smedley, Stith, & Nelson, 2003). A complex set of interrelated social, economic, and environmental factors create and sustain disparities. Thus, they are experienced differently among and within diverse communities and population groups (Laveist, 2005; Smedley, et al., 2003). As a result, addressing disparities requires understanding and assessing community-based experiences from the perspectives of those affected directly or indirectly.

Efforts to address disparities which are shaped by community knowledge and experiences are more likely to reflect the specific needs of a given community (Findley, et al., 2003; Garvin, Cheadle, Chrisman, Chen, & Brunson, 2004; Israel, Schulz, Parker, & Becker, 1998; Wallerstein & Duran, 2006). Understanding perceptions of disparities as an issue of concern in the community and the underlying causes that lead to them is important for formulating interventions that reduce or eliminate them. Assessing readiness nurtures awareness of community social norms, cultural beliefs and practices; social, political and historical factors that shape community life; community assets and existing networks; and past experiences or other circumstances that may influence future partnerships and initiatives. This knowledge allows public health researchers and practitioners to weigh the readiness of a community to collaborate
on disparities efforts by facilitating the development of partnerships and interventions that are meaningful, and sustainable.

ASSESSING COMMUNITY READINESS

The Community Readiness Model (CRM), originally developed for alcohol and drug abuse prevention, assesses a community’s readiness to implement prevention programming (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). Based on the transtheoretical model, commonly referred to as the “stages of change model”, it presents a framework for recognizing that communities are at different stages of readiness for implementing substance prevention programming and initiatives (Borrayo, 2007; Edwards, et al., 2000; Findholt, 2007; Oetting, Jumper-Thurman, Plested, & Edwards, 2001; Plested, Edwards, & Thurman, 2007). For example, a successful intervention in one community is likely to fail in another if the community is not ready to implement. Substance abuse research has demonstrated that community buy-in is a key to program success and effectiveness (Edwards, et al., 2000). Understanding community readiness can help in the development of public health efforts by assuring that they are consistent with community conceptualizations of an issue and motivation to engage in collaborative partnerships (Edwards, et al., 2000; Findholt, 2007; Plested, et al., 2007). Hence first assessing readiness allows researchers or outside organizers to meet communities were they are, and on their own terms.

The CRM is based on four principles: (1) a community’s level of readiness is issue specific; while a community may be at a high level of readiness for efforts to address disparities related to health behavior, they may be at a low level of readiness to address the social or economic determinants of health; (2) a community’s readiness can be assessed in a systematic way; (3) once assessed, community readiness can be increased over time; and (4) interventions to increase community readiness to address health disparities should reflect their current level of readiness (Edwards, et al., 2000; Findholt, 2007; Plested, et al., 2007). Working within thereadiness framework facilitates stakeholder ability to move forward with health disparities efforts in a way that is appropriate, measuring change along the way.

DETERMINING READINESS IN HOLYOKE

The goal of this project was to determine the most effective way to support health disparities-related initiatives in Holyoke, a mid-size in the Western part of Massachusetts and approximately two hours away from the state’s capital, Boston. Holyoke has a diverse, but relatively large Latino population, mostly Puerto Rican. A key component of the research was to engage respondents for the purposes of building cross community partnerships between CM and local stakeholders. The research aims were to, (1) determine community readiness for disparities mobilization, (2) assess community priorities and needs, and (3) identify community assets.

Stakeholders in Holyoke were approached for this pilot as community leaders and staff from nonprofit organizations that had previously requested information from CM, and had expressed interest in establishing a partnership. Holyoke had also previously hosted a disparities conference demonstrating an interest in working on disparities. Additionally, Massachusetts Department of Public Health (MDPH) data indicated that Latino residents in Holyoke bear a disproportionate burden of chronic disease, addiction and infections disease when compared to overall state and regional populations. Specifically disparities can be seen in diabetes, heart disease, childhood asthma, infant mortality, HIV/AIDS, teen pregnancy and substance abuse.
Additionally, census data revealed significant socioeconomic disparities in comparison to the state overall.

Forty four percent of residents in Holyoke identify as Latino (39.5 percent as Puerto Rican). Racially, 85 percent of Holyoke residents describe themselves as white, 8 percent as some other race, 3 percent as Black, 2 percent as Asian and 1 percent as Native American. Just under fifty-six percent of the civilian population aged 16 and older is in the labor force, and the median household income is $34,496, more than sixteen thousand dollars below the state median of $64,509. In 2009 the per capita income was $19,673 and 25.2 percent of Holyoke’s families lived below the poverty level. Among households, 33.7 percent receive Social Security income, 12.9 percent receive Supplemental Security income, 8 percent receive public assistance income, and 29.6 percent receive food stamps. In addition to having a high number of residents living under official poverty thresholds, the city also has a low homeownership rates Fifty seven percent of housing units are renter occupied, among which almost half, 46.3, spend 35 percent or more of their income on rent. The issues residents face given their economic hardship and low levels of employment are exacerbated by the population’s low level of education. Twenty six percent of the population aged 25 years or over has less than a high school education, and 29.2 percent have a high school diploma or equivalency. (U.S. Census Bureau, 2009)

In 2009, 54.4 percent of families with children under 5 and 43.1 percent of families with children under 18 were living in poverty. For female headed households, 67 percent of families with children under 5 and 54.3 percent of families with children under 18 were living in poverty. (U.S. Census Bureau, 2009)

**RESEARCH DESIGN AND METHODOLOGY**

This was a qualitative assessment that employed snowball sampling for recruitment and key informant interviews for data collection. CM identified initial community leaders, who assisted in identifying additional community leaders for subsequent recruitment. Consequently eight (8) individuals representing key informants were selected for interviews. Readiness assessments have been conducted using both quantitative and qualitative survey instruments. An interview script was developed for an open-ended interview format, and interviews were approached as discussions as opposed to employing a question and answer format, to establish rapport and build trust by allowing participants to guide the direction of the interviews. These qualitative tools were adapted from the key informant questionnaire developed by the Tri-Ethnic Center for Prevention Research (Tri-Ethnic Center for Prevention Research, 2007).

The participants included elected members of local government, health and social services practitioners and providers. Participants were 75 percent Latino and the ratio of men to women was 3:5. Community leaders were contacted by telephone, at which point CM’s goals and the research goals were explained. Participants were then invited to participate in an interview. Interviews lasted 1-1.5 hours and were held at the primary workplace of participants. Interviews were conducted in English (3), Spanish (3), and bilingually in both English and Spanish (2).

According to the Tri-Ethnic Center for Prevention Research (2006), there are nine stages of readiness, and five key steps must be taken in order to determine a community’s readiness. These steps include: issue identification, defining the community, conducting key informant interviews, and analyzing data to determine readiness and implementing community specific strategies (Stanley & Edwards, 2006). The model by Edwards et al. (2000) was adapted for use
in this study. The nine stages of community change were collapsed into three phases of readiness with corresponding characteristics and criteria for collaborative intervention (see Table 1). The framework was developed to link the readiness assessment with specific interventions to support disparities-related action. Intervention criteria were based on the expertise of CM and the level of readiness demonstrated by the community.

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<tr>
<th>Readiness Phase</th>
<th>Collaborative Intervention</th>
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<tr>
<td>Phase 1:</td>
<td>Supply data, provide technical assistance and support, support in identifying additional community stakeholders, identify internal and external resources</td>
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<td>Communities have little to no awareness of health disparities, or they are beginning to define health disparities as an issue.</td>
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<td>Phase 2:</td>
<td>Focus on supporting and/or facilitating existing efforts at partnership, mobilization and or coalition development.</td>
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<td>Community leaders are beginning to organize around disparities related issues. They have a sense of how disparities impact the community and are, or are not, being addressed. There is interest in partnership development and community mobilization.</td>
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<tr>
<td>Phase 3:</td>
<td>Focus on diversifying coalitions and bringing new sectors to the table, support the dissemination of best practices and lessons learned to new communities.</td>
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<td>Community leaders are building partnerships, and community-wide initiatives may be underway. These groups may have name recognition and a funding stream.</td>
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Data were recorded by hand by each of the two investigators in the language of the interviewee. Field notes were completed by each researcher immediately after the interview. Notes were exchanged, reviewed to assure accuracy and those recorded in Spanish were translated into English. Once cleaned, the data were coded thematically by each interviewer, and the codes were compared. In instances where the codes differed the data were discussed until consensus was achieved. The content was then analyzed, using the predetermined readiness criteria outlined in Table 1.

FINDINGS

During the course of key informant interviews there were three key findings: 1) health disparities in Holyoke exist within a social and economic context specific to the city, 2) the community was not in need of additional health and social services, and 3) historical experiences with outside partners, particularly researchers, were not viewed as positive or mutually beneficial.

Social and economic factors which contribute to health disparities in Holyoke

Respondents reported that Holyoke is a city facing many of the issues prevalent in urban areas where minorities comprise the majority of residents: racial tension, socioeconomic inequality, poverty and its tangent social issues, such as substance abuse, disconnected youth, hopelessness, and a desire for change. But Holyoke is different than other places where the
challenge of health disparities also exists. This city was further described as a city where two distinct communities are divided along racial/ethnic lines. One is white, primarily of Irish descent, more affluent, middle class, and located in “the hills” section of town. The other is poor, brown, Spanish-speaking, primarily Puerto Rican, and concentrated in “the flats” section of the city. There is a clear physical border that divides these two parts of the city, as well as two different trajectories for its residents. Respondents reported that residents of the flats are disproportionately impacted by poverty as well as diabetes, obesity, depression, HIV/AIDS, teen pregnancy and addiction.

Respondents expressed concerns with the lack of economic development and initiatives to address economic inequities, and did not describe any efforts to encourage small business development, nor mention any specific development initiatives underway. Many noted, however, that the city had assets that might contribute to economic development, given the city’s history as a planned city with many large vacant mill buildings.

Healthcare and Social Services

Generally speaking, health issues in Holyoke are addressed with the traditional Western treatment model. Participants described the emphasis on maintenance, such as methadone for heroin addicts, and treatment, which they reported as not successful in addressing health issues, that were a function of socioeconomic and environmental factors that would be better treated through prevention. Interview data suggested that there needs to be a shift to a more pro-active stance with a greater emphasis on prevention, whether through education, public information campaigns or, targeted health outreach and education. In addition, in order to address these complex issues, efforts need to be holistic and comprehensive as the health issues people face usually come hand-in-hand with additional health, social and economic problems.

This suggests that in order for programs to effectively tackle widespread IV drug use and meet the needs of addicts, mental health, housing and educational factors need to be addressed as well. Respondents indicated that both social and economic development was needed if health disparities are to be addressed. They described the need for programs that build individual and community capital, and/or build on the strengths and resources of the community, such as the community’s history as a planned city and community present motivation for change.

In terms of health care delivery, the recently renovated community health center offers a wide range of services such as oral health care and cooking classes that are culturally and linguistically appropriate. The health center emphasizes prevention programming, integrated health care delivery, and employment opportunities for local residents. The center, which was newly renovated in 2007, is centrally located in the downtown area. In addition, the health center has implemented the chronic care model which recognizes that disease management takes place in three overlapping dimensions: the community, the health care system, and provider organizations (Bodenheimer, Wagner, & Grumbach, 2002; Wagner, 1997; Wagner, et al., 2005; Wagner, Davis, Schaefer, Von Korff, & Austin, 2002; Wagner, et al., 2001).

Respondents agreed that there were many resources and services in Holyoke, and that help was not in short supply. However, the problem most frequently identified was that services are at times fragmented and not comprehensive. Previous initiatives in the city to tackle health issues had been erratic at best and neither focused nor sustainable. For example, many were initiated students at local institutions or outside organizations and were not sustainable.

Respondents largely associated this lack of sustainability with funding waves and research interventions spearheaded by outsiders, particularly academic partners and students who
leave at the end of their project periods. Respondents clearly stated that additional community assessments are not required, because the needs and concerns of the city and its residents are clear and have been for decades. To that end, respondents reported a need for focused and sustained action, and adequate funding to plan and organize effective efforts the many intertwined issues present in the community.

Collaboration with outside partners

According to some respondents, Holyoke is a city with a long history of “meddling” outsiders who do not have a personal stake in the community and are often not committed to long-term investment in the community. Widespread sentiments from respondents were that it’s poor; primarily Spanish-speaking Latino residents that have been exploited for any number of reasons related to academic or planning projects. Some interviewees reported being suspect of outsiders such as students, researchers, and short-term programs which in the past have come to Holyoke, conducted studies, led focus groups, written papers, and then have left when their papers were published or their funding was gone. As was stated by one participant Holyoke is “the perfect little laboratory.” She said the City has a long history of students and other researchers who want to come in and study poor people with problems. She further went on to describe what she referred to as “poverty pimps”- people who profit from poverty and make money from other people’s problems. She talked of Holyoke’s rampant extreme poverty as somewhat of a money-making opportunity that people exploited (“invested in”) for financial gain and self-interest. She said these “poverty pimps” have a history of coming to Holyoke because they “want to do something,” but who those efforts benefit are the researchers and other outsiders and not the population their efforts are supposed to target. All respondents stressed the need to work with existing community resources, such as community leaders and programs.

READINESS ASSESSMENT

Respondents were aware of the disparities that existed in the community and had begun to organize around disparities related issues, such as nutrition and access to physical activity. Respondents were able to identify health disparities across a number of health outcomes and chronic conditions, and identified root causes of disparities as being socio-environmental as well as economic. One individual described the community as being in an “up-swing” in that recent efforts to address disparities were underway. Such efforts included health center initiatives, grassroots efforts at organizing public disparities-related public forums, partnerships with the local community college aimed at human capital development, community gardens, and a community-wide partnership effort to apply for a disparities-related grant targeting physical activity. These projects indicated that there was an interest in working with CM and with community colleagues in efforts to mobilize resources to tackle disparities. Although efforts were underway, the majority were disease specific or targeting health behaviors, for example groups were coming together to target physical activity and youth focused efforts targeting substance abuse prevention were in place.

With respect to social marketing and engaging diverse sectors, key community leaders already engaging in disparities elimination efforts included health and social service agencies, as well as the local community college and a non-profit community development organization. Efforts were also in place to expand public awareness of inequities. For example, according to one participant, a local Spanish language newspaper, *El Diálogo* undertook efforts to raise awareness of differences in public services, such as trash collection and parks between minority
and majority neighborhoods and was working to develop a disparities forum. “… a paper of the people.” She said that residents can go online and submit articles about issues they are struggling with in the community, and that the paper will print them.

Overall, despite past experiences with outsiders, community leaders were open to expanding partnership efforts to address disparities. There was a sense of hope among respondents that current efforts would lead to future success. It was apparent that those leading the fight against health disparities were not new to the game. Collectively they had a great breadth and depth of knowledge of local and regional disparities, as well as a history of commitment to improving the health and well-being of the community. Based on the readiness criteria outlined, Holyoke was determined by the authors to be in readiness Phase 2. Again, this is the stage where community leaders have identified an issue and are moving into the action phase.

PROJECT OUTCOMES

Essential to this work was the research methodology itself in that it was action-oriented and aimed at fostering partnerships between CM and Holyoke stakeholders. Unlike traditional research and assessment, the purpose of the readiness assessment employed here was twofold: to assess community readiness for disparities mobilization and, to facilitate community partnerships. A qualitative adaptation of the traditional readiness assessment was an effective means of establishing rapport and building trust, particularly given that initial leaders contacted for interviews shared some hesitance towards another group coming in to study their community. In addition, using the snowball technique for recruitment gave us some degree of credibility and allowed to identify key informants working in the community who might have otherwise been overlooked. This research allowed CM to work with leaders in Holyoke in a manner that was reflective of community-identified focus areas, and understanding the level of community readiness assured that CM’s approach was community-specific while investigator feedback after qualitative interactions and follow-up lead to an approach that was culturally and linguistically appropriate.

In order to establish new relationships and enhance existing relationships, the readiness assessment data were set in the context of a community report, along with recommendations for CM. The results were presented to CM accompanied by guidance for community collaboration, which was based on findings related to past experiences with outside partners. Examples of guidance provided to CM by the authors prior to the community meeting can be seen in Table 2. A meeting between community stakeholders and CM was then scheduled. This meeting was organized and facilitated by the investigators. Key findings from the readiness assessment were discussed among CM and community stakeholders from Holyoke, and parameters for moving forward with the collaborative efforts were established. This included defining the nature of the stakeholder relationship and the role of CM.
Table 2: Readiness Characteristics by Phase

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<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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<tr>
<td>-Lack of public will (no interest or motivation)</td>
<td>-Recognition of health disparities across the health continuum</td>
<td>-Community action under way</td>
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<td>-Little to no data on racial and ethnic disparities in health.</td>
<td>-Some collaboration to address disparities</td>
<td>Efforts supported by the local climate</td>
</tr>
<tr>
<td>-Work has not been linked to community perceptions and definitions of health disparities</td>
<td>-Some social marketing to bring in non-health related sectors</td>
<td>-Established multi-sectorial collaboration</td>
</tr>
<tr>
<td>-Lack of or little awareness of the concept health disparities</td>
<td>-Some research underway</td>
<td>-Commitment to working across disciplines</td>
</tr>
<tr>
<td>-No social marketing has been done around health disparities</td>
<td>-Emphasis on addressing health care issues specifically, and little focus on the socioeconomic determinants of health</td>
<td>-Policy and program development underway</td>
</tr>
<tr>
<td>-Lack of community voice, participation, engagement</td>
<td>-Leadership around the issue is emerging</td>
<td>-Efforts to document and replicate action</td>
</tr>
<tr>
<td>-No immediacy to address health disparities</td>
<td>-Efforts in the discussion or planning stage</td>
<td>-Efforts to address non-health specific, but issues related to disparities</td>
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<tr>
<td></td>
<td>-The possibility for partnerships is being explored</td>
<td>-Community buy-in across sectors and/or populations</td>
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<tr>
<td></td>
<td>-Small-level efforts to increase health and well-being in different areas emerging or in the early stages</td>
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<tr>
<td></td>
<td>-Some interest in working across disciplines</td>
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One of Holyoke’s primary interests in initially reaching out to CM was the development and implementation of a local disparities forum. After the initial planning meeting it was agreed that the focus of collaboration with CM would entail support around the development and planning of a local disparities forum. CM and local Holyoke partners hosted Holyoke’s second annual disparities forum, “Confronting Health Care Disparities: Is Commonwealth Care the Answer?”. At a time when the state was rolling out its version of “universal care” it seemed like a timely opportunity to highlight a community with high rates of “coverage” and high rates of disparities. The conference focused on the findings of the Institute of Medicine Report, Unequal Treatment, sending the message that access doesn’t necessarily lead to quality care or the elimination of health disparities (Smedley, et al., 2003). In addition, forum speakers warned that health care was not the cure for unhealthy communities riddled by chronic poverty, and socioeconomic disinvestment.

It was also decided that CM would provide the community with technical assistance with grant proposals and funding opportunities. Traditionally CM community partners receive funding information via the CM list serve; here CM provided support with grant seeking and proposal development. Partnering with community leaders, one of whom participated in the initial assessment, CM applied for funding for an asset-based youth development project, with hopes of increasing local infrastructure and tackling the social determinants of health in Holyoke.

Assessing community readiness in Holyoke facilitated partnership development in three key ways. First, the researchers were able to build rapport with local community members through open-ended qualitative interviews; this methodology helped in establishing trust.
Second, assessing readiness brought to light community assets and infrastructure, which CM was able to build upon in partnership with community members. Finally, the readiness assessment results overall provided CM with important contextual information about the community such as past experiences with partnerships and public health initiatives, as well as community dynamics and the social determinants of health in Holyoke. This information coupled with the initial relationship forged by the researchers and recognition of community assets allowed CM to work with the community on initiatives important to them.

CONCLUSION

Determining community readiness in Holyoke as part of partnership development afforded CM an understanding of community interests, needs, concerns, and assets, while simultaneously building local partnerships. In addition, gauging readiness nurtured awareness of community social norms, cultural beliefs and practices; social, political and historical factors that shape community life; community assets and existing networks; and past experiences that influence the development of partnerships and successful initiatives. This knowledge facilitated CM to engage in partnership with Holyoke stakeholders, and to provide technical assistance on local level disparities initiatives. Despite the success of initial project efforts CM did face important challenges. Because it is based in Boston, CM is, in many ways, more than just a two-hour drive away from the realities of Western Massachusetts where Holyoke is located. Given the distance, CM had difficulty maintaining relationships with community stakeholders. This was also in large part due to the fact that CM is a small grassroots coalition that at the time was undergoing a staffing shift during a key time in the partnership. Partnerships require consistent contact, communication and coordination, in addition to a long-term plan of action. Gaps in staffing and a lack of local CM personnel to support efforts in Holyoke limited the long-term local impact CM’s efforts at partnership.

Although the partnership fostered through this work held much promise, the ability to sustain it in the long term proved difficult, this is not unique to community partnerships. The basic resources necessary to oversee any developed efforts between CM and Holyoke from inception to evaluation were not present. Holyoke stakeholders were found to be highly motivated, knowledgeable of disparities issues at the local level, and prepared to spearhead disparities reduction efforts, however, individual partners and the city lacked the infrastructure and sufficient personnel to engage in and sustain an ongoing partnership with CM. Furthermore, all involved were committed, but stretched thin and did not have the time outside of their own work to take the lead on external efforts in partnership with CM. Similarly, CM was in need of a full time community coordinator in Holyoke and the financial resources needed to facilitate an ongoing relationship between the two communities.

Future action-oriented research partnerships must identify and ameliorate barriers to sustainability, while assuring purposed initiatives are aligned with community priorities and responsive to community data needs and concerns. Although community engaged research can be successful, its potential impact can be constrained by partner capacity, community infrastructure and inequitable power dynamics as well as resource distribution. Our experience revealed that although community stakeholders were ready to move forward, adding an outside partner, such as CM was not sustainable over the long term. Although CM was effective in providing technical support on targeted initiatives, with limited resources and distance between the cities an ongoing relationship was difficult to sustain. Furthermore, interviews highlighted
community frustration with outsiders; particularly researchers and students who they felt were not responsive to, nor respectful of their priorities. Although well intentioned, research initiatives, inclusive of student projects, that do not engage community members as equitable partners only hinder progress.

REFERENCES


Assessing Community Readiness for Disparities Mobilization - Sprague et. al.