Georgia Health Policy Center




PROMOTING EQUITY THROUGH HEALTH, TRANSPORTATION, AND COLLABORATION

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EXECUTIVE SUMMARY

In recent years, public health and transportation sector collaboration to improve health has primarily focused on promoting safety and active transportation. Some of these multisector strategies have unintentionally created "cascade effects" in communities experiencing significant and entrenched inequities, influencing critical community assets such as business locations, access to jobs, and community health. Addressing inequities through infrastructure investment requires a broader, multifaceted approach between health, transportation, and other infrastructure stakeholders.

The purpose of this project is to catalyze a community of practice that brings together infrastructure, environment, and public health professionals and community stakeholders to better address health equity through infrastructure planning. It included multisectoral design and delivery of a session at the American Public Health Association (APHA) 2017 Annual Meeting, a networking event and bus tour, and a capacity-building component. Results from these activities, with input from community partners, will generate multisector evaluation and recommendations for the community of practice.

The APHA session, Promoting Equity Through Health, Transportation, and Other Infrastructure Collaborations, was jointly planned and organized by experts at the U.S. Department of Transportation (USDOT), the Centers for Disease Control and Prevention (CDC), and the Georgia Health Policy Center (GHPC) at Georgia State University. The session was designed to broaden a conversation between public health, transportation, and other infrastructure stakeholders on the importance of a multisector, "health in all policies" approach to integrating health and equity into infrastructure decision-making.

The partner organizations also planned a bus and walking tour of multisector infrastructure projects in Atlanta that have impacted health equity, several of which were highlighted in the session. Finally, working with community partner ECO-Action, the project assesses capacity development for community-based organizations (CBOs) that would potentially participate in a multisectoral community of practice to increase collaboration between public health, environment, and infrastructure sectors and stakeholders, and integrate health and equity into infrastructure decision-making. This report summarizes the findings from the session, tour, and input from participating CBOs.

Based on the results throughout the project, there are significant opportunities to promote health equity through consistent and collaborative partnership among infrastructure planning, public health, and community stakeholders. Moreover, public and private investment into community participation through capacity building for CBOs holds significant potential to bring a holistic community health perspective into sector-specific policies. Structural barriers to capacity building for smaller, younger, or more community-grounded CBOs are identified in existing planning and grantmaking practices, along with clear strategies to transform these practices in ways that would address environmental health justice concerns from both sides — infrastructure and environment, and social and economic inequities. Evidence- and data-based solutions include funding practices that prioritize community-grounded CBOs, establish a capacity-building funding pipeline for such CBOs, and evaluate the success of funding activities through indicators of collaboration, participation, and mutual objectives. Specific evidence-based capacity-building strategies are described in the report.

Some specific tools and approaches to incorporate health justice into infrastructure planning are becoming more widely available. Community-engaged planning, through CBOs and community-based

participatory research (CBPR) partnerships, are one approach. Health impact assessments are another tool that has been used effectively to increase the use of human and environmental health evidence, community health metrics, and community and stakeholder input into projects, plans, and policies. Many community development and community health initiatives have unrealized potential to collaborate across sectors and with community stakeholders.

Core capacity building and engagement approaches have been identified and can be implemented in order to support the role of CBOs in facilitating stakeholder participation in the policymaking process. These strategies were training and technology transfer, technical assistance, community-based participatory research, community organizing/social action, authentic participation processes, and empowerment. These activities can be designed into planning and engagement stages of public initiatives as subawards to CBOs or to academic-CBO partnerships as described below. They can also receive direct investment from foundations or other private funders using a pipeline approach to routinely assess capacity and support access to technical assistance, mentorship, and other resources based on the results.

In either type of investment, the organizational and funding accountability and structure need to set project goals and strategies in a collaborative relationship, and reward indicators of good collaboration such as trust, time taken to build relationships, mutual understanding, aligned goals, power and resource sharing, and capacity growth. Funders must avoid creating a hierarchical structure in which goals, activities, and deliverables are predetermined by the funder. Instead, a mutual agenda and shared values need to be cocreated between the CBO and the funding organization. Funders must also be careful not to underpay CBOs for their expertise and performance. Rather, they should expect to invest more into the operations of smaller or less established organizations, or those that are formed from communities that experience multiple inequities, in order to support essential administration, infrastructure, and engagement that can be more distributed across people and projects in larger organizations. Knowledge, values, and belief differences must be reconciled or at least managed; trust must be built. Support efforts need to be customizable, including personalized technical assistance, mentoring, and peer learning with other CBOs.

This project provides actionable steps to promote environmental health justice, within Georgia and in other places. To follow up on the conference session, tour and networking event, and survey of organizations, it is recommended to hold a multisectoral meeting to present and discuss the results, and convene the community of practice (COP). Participants in each phase of the project can form the core of this event and the COP, as well as their key partners and funders. The COP can facilitate more routine and participatory collaboration across health, environment, transportation, and community stakeholders, using the strategies described herein to center equity in decision-making practices. One charge of the COP will be to institutionalize this transformation to create structures around data transparency, education to prepare citizen scientists and community leadership, and accountability measures to ensure that the practices remain authentically centered in communities and provide equitable participation.

KEY TERMS

Health	A "state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity." Furthermore, health is the ability of an individual or group "to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment." *1948 World Health Organization Constitution and the 1986 Ottawa Charter for Health Promotion*
Health equity	Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. *Healthy People 2020.* When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'" *Braveman, P.A.*
Health inequity	A difference or disparity in health outcomes that is systematic, avoidable, and unjust. *Inequity* refers to unfair, avoidable differences arising from poor governance, corruption, or cultural exclusion, while *inequality* simply refers to the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources.
Social Determinants of Health	Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world. *Healthy People 2020/Commission on Social Determinants of Health, World Health* Organization
Lifeline infrastructure	Infrastructures that are interdependent in terms of impact on community and societal well-being and potential of exacerbating inequities. This infrastructure includes the physical and operational systems that provide electric power, natural gas and liquid fuel, telecommunications, transportation, and water and wastewater transmission. Such systems are commonly referred to as "lifelines" because they are vital for the economic well-being, security, and social fabric of the people they serve.
Health in All Policies	Any strategy that strengthens the link between health and other policies, creating a supportive environment that enables people to lead healthy lives.
Health Impact Assessment	A systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. Health Impact Assessment (HIA) provides recommendations on monitoring and managing those effects: • Screening, to determine whether a proposal is likely to have health effects and whether the HIA will provide useful information • Scoping, to establish the scope of health effects that will be included in the HIA, populations affected, sources of data, and methods to be used • Assessment, which is a two-step process that first describes the baseline health status and then assesses potential impacts

	• Recommendations suggest design alternatives that could be implemented to improve health or action that could be taken to manage health effects • Reporting presents findings and recommendations to decision-makers and stakeholders • Monitoring and evaluation include monitoring the implementation of HIA recommendations. Evaluation can be of process, impact, or outcomes
Community Health Needs Assessment	Part strategic plan and part grounding rod. The Patient Protection and Affordable Care Act of 2010 (ACA) requires tax-exempt hospitals to create a hospital Community Health Needs Assessment (CHNA) every three years. This hospital CHNA is developed alongside community stakeholders. The CHNA requirements include: • A demographic assessment identifying the community the hospital serves • A survey of perceived health care issues • Quantitative analysis of actual health care issues • Appraisal of current efforts to address the health care issues • Creating a three-year plan with the community to address other issues collectively
Environmental justice	The fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. This goal will be achieved when everyone enjoys equitable protection from environmental and health hazards, and equitable access to the decision-making process to have a healthy environment in which to live, learn, and work. The environmental justice movement isn't seeking to simply redistribute environmental harms but to abolish them. *Adapted from USEPA and EJ Network*
Environmental riskscape	Health hazards in the environment "driven by the distribution of power, privilege and economic resources." Research has linked broad factors such as residential proximity to environmental hazards, perceived poor neighborhood conditions, and daily stressors with higher allostatic load components, which is the combined biochemical indicators of physical and mental stress. This indicator can help reveal the complex ways in which socioeconomic inequities, environmental hazards of many sorts, and human relationships can interact to produce cumulative health effects.
Successful aging	The capacity to function across many domains — physical, functional, cognitive, emotional, social, and spiritual — to one's satisfaction and in spite of one's medical or other conditions. It implies that no matter the state of health, a person may still seek to optimize his or her capabilities, social connectedness, and satisfaction with life. Optimal or successful aging means getting to quality of life destinations — not just doctor's appointments, but having access to social and church activities, family gatherings, healthy foods, and much more.
Cascade effects	When any one nonfunctioning component in a system can harm the functioning of other components. This can result in a cascading impact that can damage the ability of some communities to do well, much less thrive.

INFRASTRUCTURE AND HEALTH EQUITY

In today's world, access to essential infrastructure such as transportation, communications, water, and electricity is unequivocally necessary for community health. Inequities in the availability, cost, or quality of infrastructure become an important determining factor for health, safety, and well-being. When some portion of the population lacks access to essential health supports for any reason, it affects the overall health status of the entire community and can produce specific issues such as reduced productivity, higher costs and service loads, and human and civil rights violations. Barriers to health such as lack of telecommunications infrastructure in rural areas, contaminated water supply in low-income homes, or a lack of affordable and accessible transportation to jobs and services have clear associations with negative health outcomes. These inequities may be very pronounced across geographic areas, age groups, racial and ethnic identity, ability levels, and other sociodemographic factors that have historically regulated access to opportunity.

Lifeline infrastructures are interdependent in terms of impact on community and societal well-being and potential of exacerbating inequities. After incompleteness or disruption, the biggest threat is from aging infrastructure. This is an interconnected, interdependent system of things we use and depend on every day. It is further nested within a broader system of determinants of health and well-being. Given this complexity, and the importance of universal access to a well-functioning system that promotes and protects health, any one nonfunctioning component can harm the functioning of other components. This can result in a cascading impact that can damage the ability of some communities to do well, much less thrive. People live their lives across these systems, and not in one sector and then another. This requires a multisectoral, human-centered approach to solve the poor health and inequitable outcomes many communities across the United States face. There are complex, systemic implications when thinking about infrastructure investments and planning.

Lifeline infrastructure should be included in our approaches to improving population health, reducing or eliminating inequities, and even increasing community resiliency in the face of disasters. The set of defining characteristics that separate lifelines systems from other sectors and services include providing necessary goods and services that support nearly every home, business, and agency; providing essential services, whose disruption could create life-threatening situations; involving complex, interdependent physical and electronic networks, interconnected within and across multiple sectors; and producing a condition in which disruption of one lifeline could disrupt other lifelines in a cascading effect.

Transportation policy and plans are a key strategy in healthy lifeline infrastructure. Numerous studies demonstrate relationships between transportation policies and public health outcomes. The literature reports connections of transportation planning, engineering, and management to physical activity and obesity, heart disease, respiratory disease, injury, and mental health, as well as more complex relationships with socioeconomic security and isolation. Transportation policies, plans, and projects have the potential to affect economic and social equity, and health inequities. Access to efficient and affordable transportation systems is an important social determinant of health, necessary for access to employment and business opportunities, goods and services, and social, cultural, and political participation. Transportation practices can produce harmful externalities, such as air pollution, noise pollution, and traffic injuries, which are not equitably distributed to populations and places. They also produce amenities, such as safe, efficient, and appealing opportunities for active transportation or greenspace. The distribution of the harms and benefits from transportation are heavily influenced by

sociopolitical power and participation, which disenfranchises lower-income communities and communities of color (Cole, MacLeod, & Spriggs, 2019).

As a result, health inequities can be created by transportation policies. Traumatic experiences, which can include injury in traffic or public spaces, social isolation, and lack of developmental opportunities, increase risk for depression, substance abuse, aggression and violence, risky behavior, sleep loss and stress, and lost productivity. Environmental hazards, such as contaminated air, water, and soil, lead to many health issues, including asthma and other respiratory disease, heart disease, cancer, birth issues and learning disabilities, and economic disinvestment. Unsafe and inaccessible neighborhoods that limit outdoor activity and increase risk of injury prevent people from engaging in physical activity, reduce social interaction between neighbors, reduce access to neighborhood amenities, and increase rates of injury and disability. In the bigger picture, transportation barriers within a city or region create underinvested commercial environments in some areas and overpriced property values in others, leading to reduced access to healthy goods and services, higher prices, and fewer choices — including in medical care, food and nutrition, and more. Intentionally or not, transportation investment and zoning decisions have continued to create barriers to opportunity and environmental justice issues. These issues are felt most acutely by residents of color and those with low income, but they also create long commutes, social isolation, reduced physical activity, high transportation costs, high rates of traffic fatality and injury, and increased exposure to environmental pollution for nearly all U.S. residents. Infrastructure should be centered on human and ecological well-being in order to provide best value.

ENVIRONMENTAL JUSTICE AND COMMUNITY HEALTH

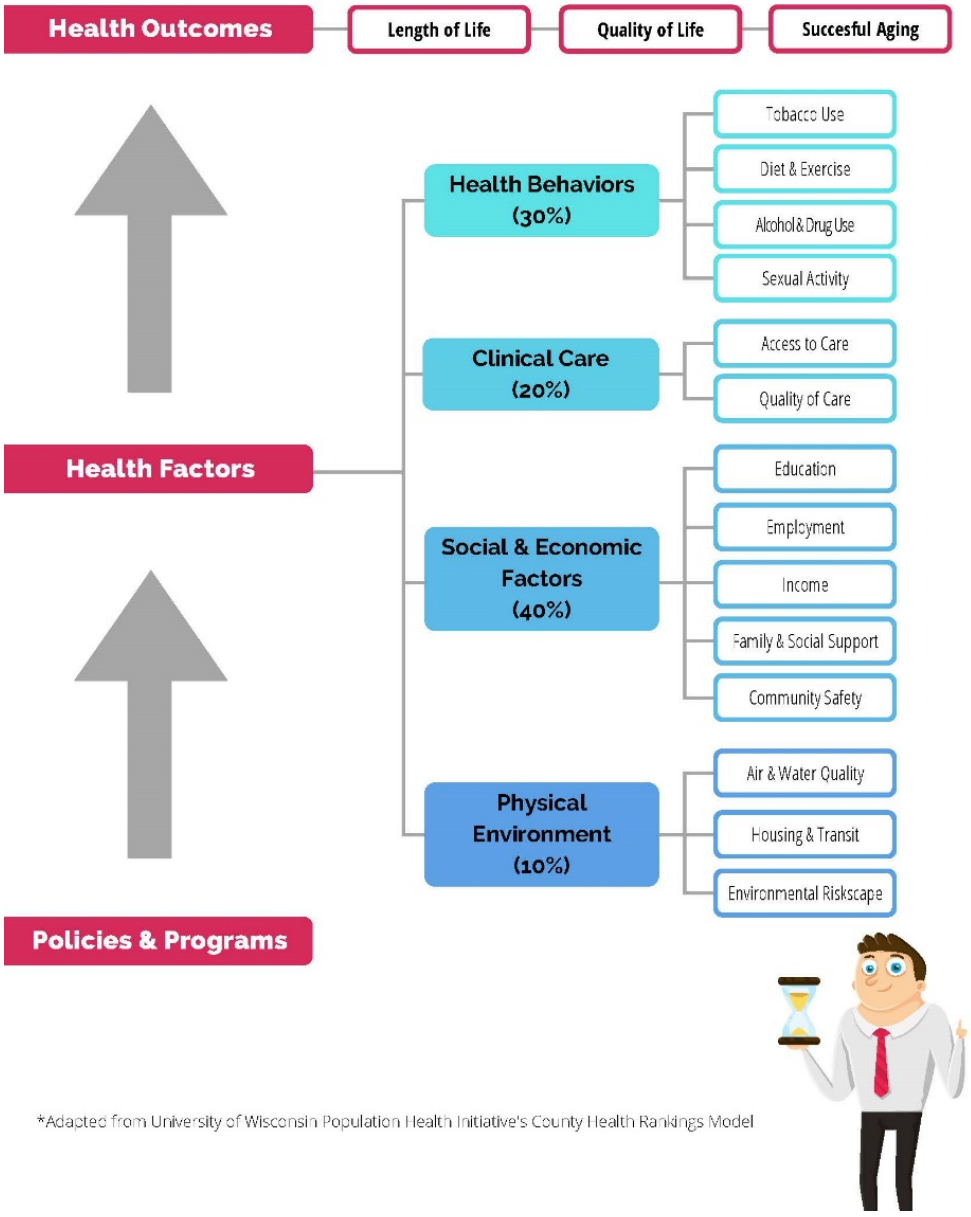
The environmental riskscape is "driven by the distribution of power, privilege and economic resources." Research has linked broad factors such as residential proximity to environmental hazards, perceived poor neighborhood conditions, and daily stressors with higher allostatic load components, which are the combined biochemical indicators of physical and mental stress. This indicator can help reveal the complex ways in which socioeconomic inequities, environmental hazards of many sorts, and human relationships can interact to produce cumulative health effects (Mair, Cutchin, & Peek, 2011). Public agencies have not always moved to mitigate government and industry practices (whether intended or unintended) that have an adverse impact on poor people and people of color. Grassroots community organizations have emerged to respond to practices, policies, and plans that appeared likely to cause harm (Bullard & Johnson, 2000).

As researchers and community representatives have started to identify and address the wide-ranging human health impacts of transportation and other infrastructure initiatives, equity dimensions have been inconsistently included. While specific environmental justice concerns have often centered around equity, both changes to infrastructure planning practices and established organizations focused on environmental issues tend to lack an equity focus and minimize inclusive participation (Kjellstrom et al., 2007; Wilson, 2010). More recently, research and advocacy concerned with the direct health impacts of transportation, such as active transportation options, traffic safety, and livability, have given relatively little attention to equity dimensions, especially the less immediate impacts such as gentrification, policing, and displacement (Lee, Sener, & Jones, 2017; Northridge & Freeman, 2011).

New Practices to Link Communities and Planning

Figure 1 is derived from a model developed by the University of Wisconsin Population Health Institute pulling together numerous sources of evidence regarding the role of all aspects of life in producing health. View the original version at https://www.countyhealthrankings.org/what-is-health. This version highlights the role of comprehensive environmental health in health outcomes over the life course. The role of infrastructure in the Physical Environment section of the health factors model is readily apparent, as it is closely linked with effects on air quality, water quality, transportation, and other environmental risk factors. However, it impacts all of the other sections in significant ways as well. Health Behaviors are impacted when opportunities for active living are reduced by walking and bicycling environments that have traffic or assault hazards. Another example is if stress and anxiety triggers are created by fear of exposure to toxins, leading to self-medicating behaviors with tobacco or alcohol. Telecommunications infrastructure may have considerable influences on access to information about healthy behaviors. In related ways, Clinical Care may be affected by access to telecommunications or transportation. Most significantly for health equity, infrastructure has sizable impacts on Social and Economic Factors, affecting many levels of access to education, employment opportunities, and social networks, as well as the level of stressors that interfere with human capacity to take advantage of opportunity. As described elsewhere, all of these factors can work together to compound the risk burden for individuals and populations.

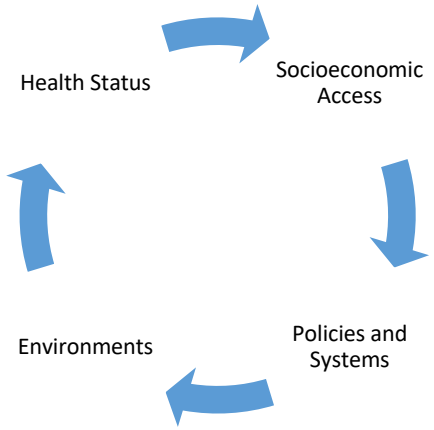
Figure 1. Model of Health Determinants



Human life and longevity, as well as lifelong health and productivity, function as an important combination of prenatal and genetic inputs, physical and mental exposures over the lifetime, and health supports during older adulthood. Across all of these factors, the effect may promote or harm well-being. Health status can be measured by such factors as physically healthy days, mentally healthy days, life expectancy or premature mortality, disease status and health care utilization, and years of disability. A health-oriented transportation system creates places that welcome people of all ages, incomes, and backgrounds to enjoy fresh food, safe and easy access to transit, streets and community spaces where neighbors interact, restorative parks and green spaces, living-wage jobs, and first-class medical, dental, and mental health services.

Through a sustainable built and natural environment, human-centered infrastructure offers high quality of life at a low cost of living — creating health and wealth. It engages affected stakeholders equitably in decision-making, relies on evidence, and offers additional support for multisector collaboration to improve health, equity, and social and economic opportunity. Significantly, health production makes a loop wherein the factors that determine whether living environments are healthy and who has access to the healthier ones result in less than optimal health outcomes and inequities, which then restrict political, social, and economic opportunity for populations relative to the health inequities they experience, for instance by affecting educational attainment, work productivity, and need for social and health services. These barriers result in lower overall economic productivity and higher costs for the entire economy and perpetuate barriers to participation in policymaking and other approaches to systemic change. Decision-making power and practices need to be integrated across the cycle.

Figure 1: Health Equity Cycle



COCREATING NEW PRACTICES

In order to foster awareness and collaboration around these issues and identify solutions, a convening, networking event and site tour, evaluation, and evidence review were conducted with stakeholders. Agency representatives, researchers, and nonprofit leaders presented the issues in a session at the American Public Health Association 2017 Annual Meeting, followed by a discussion with an audience of experts and stakeholders. Many participants also met after the session to attend a bus tour and networking event on Atlanta's west side. The project team documented and analyzed the content of these events, and integrated it with existing published literature. Detailed input was provided through a survey of community-based organizations (CBOs) conducted by a community partner subcontractor. After the 2017 session and tour, project activities were delayed until 2019 in order to revise the scope and timeline to better partner with CBOs; the evaluation, review, and final report were conducted in 2019 and 2020.

Convening Session

The session at the American Public Health Association 2017 Annual Meeting was jointly planned and organized by experts at the U.S. Department of Transportation (USDOT), the Centers for Disease Control and Prevention (CDC), and the Georgia Health Policy Center (GHPC) at Georgia State University. Titled "Promoting Equity Through Health, Transportation, and Other Infrastructure Collaborations," it was held on Wednesday, Nov. 8, 2017, 10:30 a.m.-noon (Session 5119.1), in Atlanta, GA. The session was designed to broaden a conversation between public health, transportation, and other infrastructure stakeholders on the importance of a multisector, "health in all policies" approach to integrating health and equity into infrastructure decision-making. Collaboration between public health and transportation sectors to improve health has primarily focused on promoting safety and active transportation, in part through infrastructure and built environment strategies. Some of these multisector strategies have

unintentionally created a cascade of effects in communities experiencing significant and entrenched inequities, influencing critical community assets such as business locations, access to jobs, and community health. Addressing inequities through infrastructure investment requires a broader, multifaceted approach between health, transportation, and other infrastructure stakeholders. This session is intended to build on existing public health and transportation collaborations in which stakeholders share, apply, and improve on the evidence to systematically reduce or eliminate inequities. This session provided an overview of lifeline infrastructures (i.e., transportation, electric power supply, telecommunications, waste stream, and water supply) and several examples of multisector collaboration and decision-making processes that have been used to successfully address inequities. The presentations will be followed by a facilitated discussion among participants designed to spark cross-sector collaboration, including identifying strategies to engage other infrastructure stakeholders.

The session was delivered as designed, with around 50 attendees. Stipends were offered to increase stakeholder participation. Six individuals took advantage of registration stipends, and two attendees requested travel stipends. The following presentations and discussion took place during the APHA session. Additionally, 35 participants registered for the coordinated bus tour that afternoon. The following presentations were given, followed by facilitated discussion.

- **Lifeline Infrastructures and Their Importance to Community Well-Being and Equity.** Presenter: Leigh Alderman, Georgia State University, Georgia Health Policy Center. Leigh Alderman provided a high-level overview of types of lifeline infrastructures (transportation, electric power supply, telecommunications, waste stream, and water supply). This also described how they provide communities access to health-promoting sanitary protections and help them integrate into social and economic life and, therefore, influence well-being and equity.
- **Ecological Approach to Gentrification with Social Justice: Chicago's Pilsen Neighborhood.** Presenter: Kevin Moody, USDOT, Federal Highway Administration (FHWA). A community-led set of tweaks to a road project in the Pilsen neighborhood of Chicago fostered incidental but desirable social justice outcomes. This presentation described aspects of the project that validate the emerging best practices for eliminating health and other inequities. Key aspects included working at relevant scales, adjusting institutional arrangements, applying life course trajectories as metrics, and coordinating the lifeline infrastructures.
- **Equity Issues and Opportunities in Creating the Atlanta BeltLine.** Presenter: Ryan Gravel, SixPitch Inc. Creating cities with such basics as public transit and parks that enable people from varying backgrounds to interact with each other, to get to know each other, and, more fundamentally, see each other, will help create a social and cultural environment that will allow people to solve the bigger problems facing our world. If our only aspiration for the Atlanta BeltLine was new housing and jobs and green space, then we succeeded, but the vision for the BeltLine included

ensuring the success of the people already living there as well. The jury is still out on whether or not the BeltLine project has been successful at ensuring equity, but it's not too late.

- **Infrastructure Improvements for Managing Youth Violence in Atlanta.** Presenter: Volkan Topalli; Department of Criminal Justice and Criminology, Georgia State University. This presentation provides new knowledge about the relationship between the ecology of crime and infrastructure improvements. A very small number of addresses in Atlanta are consistently the source of most of the perpetrators of violent crimes. I examine attempts to rearrange the infrastructure in the street segments outside those homes as a means of enhancing positive cognitive behaviors and social skills. These enhancements promote equity by reducing and eliminating, rather than simply displacing, the factors that contribute to youth crime and violence.

Facilitated Discussion

A follow-up discussion was facilitated by James Dills from GHPC and was guided by the following prompts:

1. In our experience at GHPC, most stakeholders readily accept the need for cross-sector and transdisciplinary collaborations, but the most common question is, where do you start? So for our panelists here today, would you please provide some insight on how the collaborative efforts you've just discussed began and how they have been funded?
2. From the transportation side of things, the National Academies' Transportation Research Board has invested a lot of resources into knowledge products such as the Eco-Logical Approach, which aim to help collaborative stakeholders —
    a. Translate their values into actionable elements;
    b. Create a transparent distinction between means and ends;
    c. Model their values so that any action agent can reliably predict interactions and identify consequences that matter to every other stakeholder;
    d. Facilitate comparisons and trade-offs of those consequences when approving projects and programs; and
    e. Coordinate and optimize the design, financing, delivery, and operations of infrastructure renewal projects across multiple administrations.
3. What processes or tools did you use in your work to accomplish some or all of those elements?
4. Would any of the panelists like to share some thoughts on how to monitor and evaluate the impacts of these types of collaborations? Who conducts evaluation of these types of projects? How is it funded? How is it used?
5. Given the experience of the panel and audience, and what they've heard in the session, in a couple of sentences, what is your vision for healthy and equitable lifeline infrastructure?

Networking Event and Site Tour Related to the Session

The participating organizations also planned a bus and walking tour of multisector infrastructure projects in Atlanta that have impacted health equity, several of which were highlighted in the session.

- BEGIN. Pick up at two downtown locations, one at conference site and one near the conference hotels.
- STOP 1. Walk a loop — across BeltLine down to the retention pond, over to and up the stairs in Ponce City Market to BeltLine, and to bus.
    - Message: An example of coordinating multiple programs such as water management and bicycle/pedestrian infrastructure, and public-private partnerships, but resulting pace of development and property value change exceeded planning capacity

- EN ROUTE. Discuss history of Freedom Parkway, interstates, Marietta Street and railroads, Northside Drive, and Hollowell Parkway as viewed.
- STOP 2. Proctor Creek embankment overlooking the floodplain
    - Message: Atlanta's ecological opportunities for economic transformation through water and transportation infrastructure, coordinating housing development
- STOP 3. Lindsay Park.
    - Message: Creating green infrastructure plans to restore dignity and build capacity in citizen science and civic leadership

- EN ROUTE. View progress on Boone Boulevard green street and discuss multisectoral, interagency, and interjurisdictional collaboration in its planning.
- NETWORKING EVENT. End at Lean Draft House for networking between tour participants.
- END. Drop off at pickup locations.

EVALUATION ASSESSMENT

Environmental Community Action Inc. (ECO-Action) was contracted by the project team to develop questions regarding capacity development for CBOs that would potentially participate in a multisectoral community of practice to increase collaboration between public health, environment, and infrastructure sectors and stakeholders. ECO-Action administered the questions to key organizations in Georgia, analyzed the results, and synthesized them into findings and recommendations.

The purpose of the evaluation was to identify and assess capacity-development strategies that will enable health and equity issues to be better integrated into infrastructure decision-making. By informing funders of these strategies, they can better support organizations as they grow in their ability to partner with federal agencies and other stakeholders. Ultimately the initiative seeks to catalyze a community of practice that brings community stakeholders together with infrastructure, environment, and public health professionals to better address health equity in infrastructure planning. To explore these strategies, they conducted interviews with "community-based" nonprofit organizations involved in environmental health, environmental justice, and health equity work and serving predominantly low-income communities and communities of color in Georgia. These were selected by the planning team to represent a range of levels of capacity, previous experience with governmental stakeholders, and perceived ability to make change in their communities.

Evaluation Methods

Qualitative Methods

Qualitative methods included a semistructured interview with a point of contact from each identified organization. A qualitative interview tool created by ECO-Action was used to assess (1) organizational capacity, (2) strategies that have been useful in building capacity, (3) barriers to collaboration and partnership, (4) past experience working with government partners, (5) outstanding community health needs, and (6) the effectiveness of mechanisms such as Community Health Needs Assessments (CHNAs) and Health Impact Assessments (HIAs).

In identifying the practices that have been helpful to respondent organizations in building capacity, we used five of the six intervention strategies identified by Freudenberg and Pastor (Freudenberg and Pastor, 2011): training and technology transfer, technical assistance, community-based participatory research, community organizing/social action, and authentic participation processes. These strategies are defined below.

Rather than asking participants whether the sixth strategy, empowerment, was a helpful intervention strategy, a separate question sought to identify what level of empowerment each organization thought they had already achieved using a power continuum based on the Power Ladder identified by the Asset-Based Community Development Institute (Kretzmann, McKnight, & Puntenney, 2005).

Interviews were conducted by an ECO-Action staff member. Interviews averaged from 45 minutes to one hour in length. While they were not taped, notes were taken to capture participant responses. Because the majority of interviews were conducted between March 1 and April 30, 2020, a period when the state of Georgia was sheltering in place due to COVID-19, most interviews were conducted by phone.

Quantitative Methods

To facilitate quantifying levels of capacity, participating organizations were asked to assess their own capacity using a modified version of the Organizational Capacity Assessment for Community-Based Organizations (John Snow Inc., 2012) developed by the ECO-Action team. This survey assesses capacity in 26 subareas within six domains: (1) Governance, (2) Administration, (3) Human Resources, (4) Financial Management, (5) Organizational Management, and (6) Program Management. The modified version of the survey asked participants to assess their performance in five of the six domains and in 13 of the 26 subareas.

The organizational capacity survey was converted from a PDF file to an online form that respondents completed from their homes or offices.

To complete the survey, ECO-Action contacted 21 "community-based" Georgia nonprofit organizations involved in environmental health, environmental justice, or health equity work and serving predominantly low-income communities and communities of color. Some were more closely aligned and embedded with a particular community, while others served a larger population. Of these, seven (33%) completed the interview and eight (38%) completed the online survey. All respondents served as either the executive director or board chairperson for the organization. The majority of the organizations were established organizations, with an average of 16 years of service as a registered nonprofit.

Scope and Limitations

Pandemic

While the evaluation team found it relatively easy to contact the smaller, lower-revenue organizations (later identified as Category A and B organizations), they found it much more difficult to contact the larger, Category C, organizations. This was made much more difficult when COVID-19 shelter-in-place requirements removed staff from the offices and made it necessary to try to contact individuals at their homes.

Length of Survey and Interview

The interview and survey were relatively long and could have been reduced to encourage participation. The evaluation team planned to offer Category B and C participants a small incentive (a lunch) to encourage participation; however, social distancing requirements instituted during the pandemic prevented the team from this activity.

Small Sample Size

The small sample limited the generalization of study results. Nevertheless, the findings and inferences in our discussion suggest meaningfulness and usefulness of this project.

RESULTS AND FINDINGS

Evaluation Survey Results

Forty-three (42.8%) percent of the interviewees had operating budgets that were less than $100,000, 43% had budgets between $100,000 and $500,000, and the remaining 14% had budgets greater than $1 million. None of the organizations interviewed had budgets between $500,000 and $1 million. For the purpose of analysis, respondents were grouped into three categories, with Category A representing those organizations with operating budgets that were less than $100,000, Category B representing those with budgets between $100,000 and $750,000, and Category C with budgets greater than $750,000. A summary of results is shown in the table below.

Organizational Capacity

Category A (< $100,000)

Organization	Year registered w SOS*/years of service	Paid full-time	Paid part-time	Number of volunteers	Annual Budget
Organization 1	1989/31	1	1	10	Less than $100,000
Organization 2	2015/5	0	1	180	Less than $100,000
Organization 3	2010/10	0	0	15	Less than $100,000

**SOS=Secretary of State*

Category B ($100,000-$750,000)

Organization	Year registered w SOS/years of service	Paid full-time	Paid part-time	Number of volunteers	Annual Budget
Organization 4	1989/31	4	1	0	$100K-$500K
Organization 5	2015/5	3	2	Over 100	$100K-$500K
Organization 6	2002/18	1	5	6-8 regular volunteers, hundreds of episodic volunteers	$100K-$500K

Category C (> $750,000)

Organization	Year registered w SOS/years of service	Paid full-time	Paid part-time	Number of volunteers	Annual Budget
Organization 7	2009/11	23	7	0	Over $1M

Organizations were also asked to assess where they were on a continuum of growth where a score of 1 represented beginning to organize a group of residents with environmental or health concerns and 5 represented operating as a full-fledged nonprofit organization. Results were as follows:

Category A average score:	3.5	(n = 3)
Category B average score:	almost 5	(n = 3)
Category C average score:	5	(n = 1)

Finally, organizations were asked to assess their capacity across five domains: (1) Governance (3 subareas — Mission and Vision, Legal System, and Governing and Advisory Board), (2) Administration (one subarea — Organizational Structure), (3) Financial Management (3 subareas — Financial Policies and Procedures, Financial Documentation and Reporting, and Financial Planning and Sustainability), (4) Organizational Management (3 subareas — Strategic and Operational Planning, Fund Development, and Stakeholder Involvement) and (5) Program Management (three subareas — Community Involvement, Project Implementation, and Monitoring and Evaluation). Assigning a value of 1 for a "basic" ranking, 2 for a "moderate" ranking, and 3 for a "robust" ranking, average scores in each for each of the three categories were:

Domain	Average Score		
	Category A (n = 3)	Category B (n = 3)	Category C (n = 1)
Governance	2.6	2.5	3.0
Administration	2.2	2.5	3.0
Financial Management	1.8	2.0	2.7
Organizational Management	2.0	2.3	2.7
Program Management	1.9	2.5	2.5

Strategies that Have Been Useful in Building Capacity

Organizations were asked to identify which of these five strategies had been useful in building capacity:

- Training and technology transfer
- Technical assistance
- Community-based participatory research
- Community organizing/social action
- Authentic participation processes

Specific results within the three organizational categories are summarized below.

Training and Technology Transfer

All three of the Category A organizations reported that they had used training and technology transfer to build capacity. Freudenberg and Pastor identified training and technology transfer processes as ones by which "community participants gain knowledge, skills, competencies, or technologies that enable them to participate in assessing and remediating environmental hazards and participating in relevant policy deliberations" (Freudenberg, Pastor, & Israel, 2011). Category A organizations reported the following examples:

- Training for board and staff by locally based foundations including the Atlanta Community Foundation, Arthur Blank Foundation, Annie E. Casey Foundation, and the United Way. One respondent referenced the Environmental Protection Agency's (EPA's) Environmental Justice Academy as a particularly helpful training event. The high level of diversity (racial and cultural, geographic, and environmental justice experience) that this training presented was also noted. Other trainings referenced included leadership training provided by their fiscal sponsor, (community organizing) training provided through the Gamaliel Foundation, county-based neighborhood leadership training, and Atlantans Building Leadership for Empowerment (ABLE, a faith-based leadership-development organization and training). One respondent indicated that "leadership has been very intentional in connecting community members to training."

All three of the Category B organizations reported that they had used this strategy to build capacity, providing the following examples:

- Department of Energy, National Environmental Policy Act (NEPA) training, watershed contamination training, and community organizing training from partner nonprofits. One organization indicated that they had built capacity by providing training to the community at large and to a new CBO.

The Category C organization reported that they had used this strategy to build capacity and provided the following examples:

- Participation in a life-changing conference had been particularly beneficial in building the executive director's capacity. They also identified personal coaching as a beneficial training strategy. The organization also indicated that they had built capacity by providing training to the community at large through coalitions that they had organized.

Technical Assistance

All three of the Category A organizations reported that they had used technical assistance to build capacity. Freudenberg et al. (2011) identify *technical assistance* as "tailored support that enables community participants to gain information or skills to solve problems or to participate more effectively in decision-making processes." Technical assistance that Category A organizations reported included the following examples:

- Technical assistance from partner academic institutions and their students, as well as water sampling, legal, accounting, and strategic plan development assistance.

All three of the Category B organizations reported that they had used this strategy to build capacity. Category B organizations reported the following examples:

- Technical assistance from partner academic institutions, data analysis for water sampling, and development of a tablet-administered survey with which to collect and collate data for healthy home assessments.

The Category C organization reported that they had used this strategy to build capacity and indicated that:

- They had provided technical assistance to other foundations, government entities, and communities.

Community-Based Participatory Research

Freudenberg et al. (2011) identify community-based participatory research (CBPR) as a process in which "community residents participate in selecting issues, designing studies, interpreting findings, and presenting results to policymakers for the purpose of reducing environmental health inequities and promoting healthier public policies." Two of the three of the Category A organizations reported that they had used community-based participatory research to build capacity.

The two Category A organizations reported that they had partnered with neighborhood residents to collect water samples from a polluted creek in the neighborhood and with a local medical school to collect health information. While community residents identified issues of concern, Category A organizations were typically less engaged in initiating and designing the study and instead were "recruited" by other larger organizations to engage the community in the community-based participatory research.

Two of the three of the Category B organizations reported that they had used this strategy to build capacity. They reported they had partnered with local organizations to identify geographic needs for greater housing justice including geographical extent of gentrification, and with a water protection nonprofit to collect and analyze water samples from a nearby, polluted creek.

The Category C organization reported that they had used this strategy to build capacity. They reported they had engaged in community-based participatory research to build a sharable online equity tracking tool.

Community Organizing/Social Action

All three of the Category A organizations reported that community organizing strategy was **"a key part of what we do,**" training community members and partnering with other nonprofits to effect change. Organizing areas include coalition building, environmental hazard cleanup, health system access, preventing hazardous industrial sites from being sited in their neighborhoods, improved stormwater management, and reduced combined sewer overflow flooding.

All three of the Category B organizations reported that they had used community organizing as a strategy to build capacity. Organizing areas included anti-gentrification effort, watershed improvement, and organizing to prevent the expansion of nuclear facilities in their community. One of the Category B respondents indicated that community organizing and training were **"how the organization got started. They were the first things we did."**

The Category C organization indicated that **"Community organizing is the lifeblood of [our organization]. It builds power, lifts the community burden, and shifts the narrative."**

Authentic Participation Processes

Freudenberg et al. (2011) identify these as "participation processes that improve community capacity by getting people involved early, providing them with information and resources for full participation, and

ensuring that outcomes reflect their participation." While most of the organizations reported the use of processes that improve community capacity by getting people involved early, providing them with information and resources for full participation, and ensuring that outcomes reflect their participation, they typically reported that they had identified processes that in some cases were implemented by others to achieve these greater levels of community participation. In fact, in responses to other questions, three of the respondents reflected on the ineffectiveness of agency-designed processes in producing authentic community engagement.

Two of the three of the Category A organizations reported that they had used authentic participation processes as a strategy to build capacity. Category A organizations reported the following examples:

- Their work in creating an environmental health section of a community benefits agreement and the attendance of regulatory staff in community-led meetings.

All three of the Category B organizations reported that they had used this strategy to build capacity. Category B organizations reported the following examples:

- Providing buses to enable community members to attend Public Service Commission meetings, the creation of a citizen science app by a college partner, and the creation of a communication tool for residents impacted by environmental hazards.

The Category C organization reported that they had used this strategy to build capacity. Most recently, they had created coalitions of nonprofits, CBOs, and community members who were working together to achieve greater health, growth, and energy equity.

Empowerment Approaches

Freudenberg et al. (2011) identified *empowerment approaches* as those by which "individuals, communities, and organizations gain power and mastery over their lives in the context of changing their social and political environment to improve equity and quality of life." Knowing that all of the organizations had made some progress on this final strategy, organizations were asked to identify where they stood on a continuum of power and engagement with reference to work with other health and equity partner organizations. In this case, a score of 1 meant unorganized community members were recipients of partner organization services and 5 indicated the organization had set its own priorities and negotiated with partner organizations and, in some cases, invited them to partner. Results were as follows:

Category A average score:	3.16	(n = 3)
Category B average score:	4.16	(n = 3)
Category C average score:	5	(n = 1)

Other Approaches Leading to Success
Respondents cited a number of additional approaches that had been critical in gaining capacity. Category A organizations reported the following examples:

- Completing and updating assessments of community needs regularly, board and staff training, work with energetic and committed people who care about community, and collaborative efforts of volunteers.

Category B organizations reported the following examples:

- Partnering with others, increasing capacity through strategic youth of volunteers, recognizing outcomes that benefit communities, partnering with an anchor institution (such as a university), strategic planning, funding support that helps pay community members, being invited into new spaces, working with a key partner who elevated the work of the Category B organization, the ability to educate the entire network of partners, and connecting with elected officials.

Category C organizations reported the following examples:

- "**The people we serve inspire engagement."** Coaching was also important to help this organization build capacity.

<u>Barriers to Collaboration and Partnership</u>
Respondents cited the following barriers to collaboration and partnership.

Category A organizations reported the following examples:

- Access to resources both in terms of funding and staff capacity — **"Many of the larger organizations we work with have much more resources than we do [but are disconnected from the local community]. This lack of resources makes it difficult to organize to address our issues."** Recruiting community members to participate in continuing initiatives (low-income individuals often don't have either the money or time to serve as volunteers), many of the active volunteers are seniors, they need to connect with younger people (working adults), the loss of key volunteers, and the fact that people's minds are often working with misinformation or no information and they are not open to new information.

Category B organizations reported the following examples:

- Difficulty in building the capacity to move to the next level, the balance between using funds to deliver more versus using them to build the organization, bringing on and keeping new staff. **"Interns are interested in the work we do, but it is difficult to have the funding to keep them,"** getting community member board members to work as volunteers, strategic planning i.e., identifying goals, articulating them and then working the plan, capturing institutional knowledge to shorten the learning curve. Larger organizations that are not focused on community engagement lean on our organization to meet their community engagement metrics (and often want this assistance for free). They get overlooked for funding because of their size. **"Funders support those they have always funded."**

Category C organizations reported the following examples:

- Building transformational relationships.

Past Experience Working with Government Partners

Respondents reported the following past experience working with government partners.

Two of the three Category A organizations reported working with federal, state, or local government as a partner:

- One organization partner worked with a federal partner as a subcontractor to collect water samples for U.S. Fish and Wildlife Service microinvertebrate studies. They also collected water samples as directed by others as part of a statewide effort. The organization found value in participating in this effort and thought that to expand their activities in the future, they needed to increase the membership of community members willing to collect samples.
- The second organization had collaborated with several state assembly members proving data and recommendations to inform a specific policy before legislation was drafted. They found the opportunity valuable for learning how bills get through the legislature. They learned their efforts could have a major impact. They also learned the importance of building relationships and that so-called "adversaries" could be become partners if you could show them that you share common values. They thought they needed more funding, more technical expertise, and greater access to media outlets to expand their efforts.
- The one Category A organization that hadn't worked with a governmental partner thought they needed to be more of a lead organization that created the program and received direct funding.

All three of the Category B organizations reported working with federal, state, or local government as a partner:

- One worked with a federal agency to provide community outreach for a technical assistance needs assessment. As an organization that the community trusted, they were able to gather more information than the technical partner leading the assessment would have been able to do on their own. They learned that the federal government has a relatively narrow area of focus (compared to that of the community).
- The second organization worked with a federal agency to gather information that would influence a congressional appropriation. They found that sometimes the government could be inflexible and a "hindrance" to true community-engaged processes. **"If there was a meeting and some people came, they [the federal partner] were done, even if the meeting was poorly advertised and the opinions expressed were that of a small group and did not represent the opinions of the community at large."** This organization has also worked with their local city government to change policy. They thought that mechanisms that would earmark a funding percentage or work tasks for community engagement would ensure that resources would be allocated for this process and help them to have a greater involvement with government projects.
- The third organization reported working with a city and local university to formulate guidelines for food pantries and other health policies. They also observed that local government projects have a more limited scope than their area of interest (for example, the study was focused only on food pantries rather than on hunger) and they tended to be "research oriented" (interested in research rather than implementation). The participant thought the project was too small to make a meaningful impact, and because the local university was the lead partner, ultimately there might be little implementation. He felt the government is not as collaborative as it could

be and that this limits the impact of its work. They thought that to expand their capacity, they would need additional knowledgeable personnel. They also would like to better engage the community; apathy and complacency are long-standing tendencies in the community they serve.

The Category C organization reported working with federal, state, or local government as a partner:

- Their organization served on the board of a quasi-governmental organization. They were recommended for the board to ensure that issues of community participation and equity were part of the organization's underlying mission. They resigned from the board when the organization failed to address identified equity issues. They believe however that, ultimately, their involvement produced positive ripple effects. As a board member, they were able to clearly articulate the value proposition of community participation. They also formed some positive relationships. They indicated that in such situations it is best to **"be courageous and to use the facts to make things happen."**

Outstanding Community Health Needs

All of the organizations reported that there were outstanding community health needs identified by the community. Many of these could be better documented through the completion of formal health assessments. The areas identified included brownfield contamination; air quality; respiratory illnesses and high asthma rates; stormwater/combined sewage flooding; gas station, biomass plant, and truck stop siting; hazardous waste sites in the community; indoor mold and other healthy home issues; abandoned tires; rats; environmental contamination from nuclear waste facilities; legacy waste storage; industrial pollution (including paper mills, and polymer and battery plants); nearby contaminated waterways; contaminated watershed (runoff, sewage, chemical spills, debris); greenspace and access to greenspace; green gentrification; the lack of locally produced food; excessive energy burdens on vulnerable communities; and the health impacts of climate change.

In identifying the need for additional health assessments, one Category A respondent indicated that (consultants or university partners) **"should consolidate the data and then let the community decide which additional assessments are necessary. [We] should not have the university partner decide the additional assessment that should be pursued."**

Another Category A respondent indicated that "assessments are helpful, but we need to engage more volunteers and community members to advocate to influence policy."

Effectiveness of Needs Assessments and Health Impact Assessment

Most of the organizations interviewed knew of at least one CHNA or HIA that had been completed or that was currently being completed in their community.

Most CHNAs and HIAs were viewed as helpful. Where completion was ongoing, there was less of a clear statement that the assessment had been helpful.

Positive actions identified based on the recommendations included:

- Sharing data with all community members
- Expanding the data-collection effort to a larger geographic area.

In most cases, the community members had been engaged in the data-collection effort. Community members served in roles that included community researcher, advisory committee member, interviewee, and focus group member.

Most thought the community could use additional information and education and training on environmental health issues and concepts. Groups that needed to be targeted included:

- Neighborhood organizations
- The public at large
- Politicians
- Youth and younger adults

One Category B respondent stated that community members know about the health threats but were sometimes afraid to talk. In a continued time of racial tension, community members of color fear for their lives and jobs if they report environmental health threats.

A Category A respondent noted that **"the community has basic knowledge, but they don't know the vocabulary. It is difficult to get people to the table. We often have to 'dangle carrots' to get them there."** The Category C respondent stated that **"community members intuitively know about the health threats. The challenge is how to change the situation."** One exception he noted was in the case of mold, where community members are less able to understand the problem.

Closing Thoughts

As a closing thought, organizations were asked, "What would you like funders to know as they develop requests for proposals (RFPs) and evaluate proposals that will consider the realities of community-based organizations like the ones completing this survey?" Responses included the following:

- **"Funders need to know that health disparities are real.**"
- **"Giving CBOs roles as leaders is an opportunity to build capacity."**
- **"The organization's size is not a true indicator of success."**
- **"We would like more funders to focus on the potential of communities/groups and not what they have done. Funders should invest in this potential and take risks."**
- **"Funders need to undo the systemic oppression of funding the oppressed."**
- They can **"generate sustainable endowments targeting historically oppressed community. That way they would not be 'giving you money' but instead would be repaying the debt or transferring funds."**

Organizations were also asked "How can RFPs be modified to allow community-based nonprofits to take on greater leadership and better access community experience?" One suggestion was that the RFP establish the CBO as "co-leader" or "co-director" of the project or research partnership. The RFP should identify the funding split between the two partners with a suggested split on the order of 60/40 (university/CBO) or some other significant percentage.

Interview and Survey Recommendations to Transform Practices

Information from published evidence and from the survey and interview participants had broad agreement, with additional actionable findings for Georgia-based organizations and their funding environment. Based on the findings from the survey and interviews, the interview team made the following observations and inferences listed below. These have been categorized based on the six investigation areas identified above.

Organizational capacity

As noted previously, respondents were grouped into three categories, with Category A representing those organizations with operating budgets that were less than $100,000, Category B representing those with budgets between $100,000 and $750,000, and Category C with budgets greater than $750,000. This separation was made based on the preliminary review of the data where:

- Category A organizations had two or fewer staff, and most but not all have 501(c)(3) status.
- Category B organizations ranged from three to 15 full-time and part-time staff. All of these organizations had gained their 501(c)(3) status.
- Category C organizations had more than 15 staff persons.

The self-reported organizational capacity was typically lowest for Category A organizations and highest for Category C organizations. Some of the smaller organizations seemed to be overconfident, self-reporting at a higher level than would be rated by others. This was particularly evident in their assessment of their use of evaluation and monitoring of their own progress, informing their activities through evaluation, and the use of data in program planning.

Strategies that Have Been Useful in Building Capacity

In reviewing the strategies for increasing capacity identified by Freudenberg and Pastor, one of the earliest respondents noted that the strategies of training and organizing assistance were the first that their organization used. These strategies helped their group of individuals working to tackle environmental health and health issues in their community become a full-fledged nonprofit organization. As the organization grew, their organization received technical assistance and resources for stronger participation. The least-used strategy was CBPR. This pattern seemed to be replicated in the other organizations we interviewed. Most identified training and organizing assistance as their first and most consistently used strategy and CBPR as the least-utilized strategy. It appears that both a level of sophistication in community resident capability and university partner willingness to engage in CBPR is needed to engage in this capacity-building strategy.

We also noted that while Freudenberg and Pastor's definition of resources for stronger participation suggests that partners should design these participation processes, CBOs often found partner-designed processes to be ineffective, and cited examples of community-designed processes, which they found to be superior.

A number of organizations identified strategic plan development and use as a significant capacity-building strategy. One noted that they had "a couple bad ones" before getting a "good one" and that their board and staff were getting better at "working the plan." One could consider strategic plan development as a type of technical assistance. Responses suggest however it might be beneficial to identify this as a separate capacity-building strategy. Additional study could better identify (1) the role

that this particular type of technical assistance plays in building capacity, (2) what makes a "good" plan, and (3) how the board and staff can best use the plan to build capacity.

We also noted that the Category C organization citied how they had helped other organizations gain capacity rather than how they had personally gained capacity. An assessment of a larger number of Category C organizations would help us to determine whether this practice was specific to the one organization we interviewed or this is a tendency of a larger group of Category C organizations.

Finally, most of the organizations interviewed noted the need for additional funding to staff up as a means to gain capacity. Many noted that funders tend to award funding based on size and took issue with the practice. In an interesting twist, one Category B organization said, **"Money does not solve everything. We [CBOs] do a lot with a little. We leverage our knowledge and relationships to get things done."** The larger, Category C organization noted, "**As a CBO, we have learned to do more with less. It is time to unlearn that, in order to be more efficient and effective in providing our services."**

Barriers to Collaboration and Partnership

A number of organizations (including the large, Category C organization) cited their belief that funders including government funders support large organizations that are not community centered, rather than their own organization. The larger organizations then subcontract with CBOs for a very low budget or even ask that they do engagement activities for free. In most cases, the larger organization cannot connect with the community as required by the RFP. Often, the larger organization takes credit for the success in community engagement, even when they have been a barrier to positive community engagement. Repeated experiences like this do not promote strong or beneficial partnerships. One respondent stated, "**Just because you are an environmentalist doesn't mean you're not racist or elitist. Despite all the funds being spent [on anti-racism work] there is still work to be done to confront privilege in academia**."

Past Experience Working with Government Partners

Most of the organizations interviewed had past experience working with government agencies and, in many cases, had encountered difficulties working with them. These problems were not specific to work with federal partners. Instead they ranged from work with local city officials up through the federal level. They thought that public agencies have relatively rigid processes and relatively narrow areas of focus. In some cases, these processes created impediments to public engagement and partnering and limited input to a small, possibly preselected community group, minimizing true public input. The respondents felt that partnerships with CBOs could create more authentic participation processes.

Outstanding Community Health Needs

Each of the organizations interviewed named a range of health issues affecting their communities, from brownfield contamination to the impacts of climate change. None of them were focused on a single issue. Most of the organizations interviewed articulated a holistic approach to health. One respondent noted, **"[Community-based nonprofits] must take a multifaceted approach. It is difficult to work with organizations focused only on a single issue."** With the multiplicity of problems facing low-income residents in environmental justice communities, community members are looking for CBOs to support solutions that will address a range of their issues, not just one. These include addressing the interconnection of environmental health and the social determinants of health, the big picture of equity, and promoting win-win solutions that address environmental and economic health.

Effectiveness of Needs Assessments and Health Impact Assessment

CBOs also identified various needs assessments that were being completed, and these had been well done. Concerns, however, were the narrowness of the assessment completed and need for implementation following the completion of the assessment. Respondents thought that community members could better understand environmental health concepts and issues, and identified groups who need to know more. They also highlighted the need to engage additional community members to be able to influence policy.

Evidence-Based Approaches to Transform Practices

A review of relevant published scientific literature and reports reinforced the findings from the CBO surveys and interviews. It also indicated that studies of environmental health impacts occur at the community level, but community members are frequently positioned as research subjects rather than collaborators, advisors, or co-investigators. As a result, there are also efforts to cocreate and evaluate models of participatory community research engagement. Collaboration methods that are standard within environmental analysis, planning, and research do not appear effective for meaningful community partnership. These partnerships take more time to build trust and to understand the issues and perspectives of the various partners. There can also be tension around sharing power and resources, which are unlikely to be equitably divided between research firms or institutions compared with citizens and CBOs. Flexibility is needed when usual research methods do not work, such as when data, especially disaggregated data, is not available for some health pathways. Traditional studies or public engagement practices often lack a reward structure that values this kind of work.

Communities often organize around a specific hazard facing their community, such as detection of a hazard or proposal for an unwanted or harmful land use. Community members may organize with each other, champions may emerge, and a group may form to represent the community interests. These groups conduct a range of activities, including research, education, social action, lobbying, and legal action. Many groups engage scientists or health professionals in order to enhance their knowledge of the problem, legitimize their concerns, and communicate the issues more clearly. CBOs often encounter problems in obtaining information from health departments, public agencies, and corporate interests (Freudenberg, 1984). Champions who emerge in these settings often contribute to the development of new CBOs, improvements in the public-engagement process, and increases in the representation of communities that are burdened with racial or economic inequities (Gallagher, 2009).

CBOs, including those at a very grassroots level, are an important part of any strategy for addressing social determinants of health. However, these organizations often face many of the same inequities as the community they serve, as well as the usual array of challenges in organizational development and sustainability. Research institutions could be effective in supporting these CBOs in multiple ways, including sharing resources, evaluating and disseminating best practices, and increasing the legitimacy of both partners' work by bridging the gap between generalized evidence and lived experience. There have been various types of community research partnerships, such as the Seattle Urban Research Center (known as Seattle Partners) and others. These partnerships often provide capacity building for partnering communities and CBOs as well as joint research agendas (Cheadle et al., 2002). Another approach has involved creating a community research advisory board with community stakeholders (Watkins, Shepard, & Corbin-Mark, 2009).

Relationships with CBOs and communities are often viewed transactionally in each discrete decision-making instance. However, their interactions and capacity are continuous and interconnected. It is important to pay more attention to the human capital of CBOs. Many established CBOs today grew out of environmental and social movements of the latter half of the 20th century and are now experiencing widespread leadership transition, while communities experiencing inequities have faced enormous obstacles to the growth of candidates who have the talent, training, and passion to step into these roles. Some CBO leadership struggles with stewarding organizations through different stages of maturity and transitioning skillsets. Many staff are underpaid and short on benefits, while overworked and dealing with on-the-job challenges as their organizations are expected to perform challenging, exceptional work on barebones budgets. They also frequently suffer emotional trauma through their work and in their communities, and leadership of color is particularly affected by these issues. A transformational, relationship-based approach from funders and agencies works to increase community capacity, particularly to create better access to social networks, influence, and partnerships (i.e., bridging social capital), especially for leaders from backgrounds that have experienced high levels of inequity (Anglin, 2004).

As of 2020, there have been multiple community research partnerships funded with environmental focus, and some federal agencies incorporated standard community input into multiple major programs (Lynn, 2000). Evaluation of a conceptual community research review model found differences in views of academic and community researchers. Community participants saw CBPR as essential to protecting the community (Watkins et al., 2009). CBPR projects have been limited but influential.

In a catalytic program, grantees were restricted to community partners who were encouraged to work with researchers, and existing partnerships were not required. Eligible applicants were CBOs or coalitions of any size with a nonprofit, 501(c)(3) tax-exempt status. The program provided technical assistance such as information sessions, individual project consultations, capacity-building sessions, and proposal review to applicants to help them move through the pipeline and transition their skills and opportunities into actionable research agendas (Tendulkar et al., 2011). In another initiative aimed at funding partnerships between research institutions and CBOs, the CBOs tended to be small, grassroots service organizations founded by community residents in order to address their community's unmet needs. These organizations often have strong relationships and experience working with other CBOs and institutional partners and a history of engaging community members, identifying community needs, and building the trust and respect of community members. Compared to institutional partners, however, CBOs tended to have fewer human resources and time, less well-developed organizational sustainability, less access to influence and resources, and less familiarity with research practices. Power is often distributed inequitably within partnerships. This research indicated that funding intended to support community research partnerships needed to structure grants in a way that rebalances power between the partners and includes extended phases that build trust between the partners and provide capacity building for CBOs (Griffith et al., 2010)

Organizational development and capacity building have also been highlighted by grantmakers as a missing element in community-centered initiatives. They cite challenges to offering these elements. There is further work to identify the capacities needed for effective community advocacy, which may vary depending on contextual and other factors. There are also challenges to accurately identifying capacity gaps and to connecting with the appropriate resources to address them. There may also be fundamental barriers to increasing the organizational capacity of CBOs; many of the measures of

capacity and the standard tools for enhancing them have been derived from profit-driven organizations and may not align with the values of community-driven entities. This may include core differences in the way that resources or decision-making power should be distributed. Long-term relationships cultivated between funders and CBOs based on mutual respect and understanding can create opportunities to provide funding and adaptive assistance where and how CBOs most need it, and to communicate frankly about struggles and goals. Additionally, funders can support coordination, mentorship, field building, and bridging between organizations at various levels of development and with different roles in the community. The work of CBOs, community engagement, and organizing delivers more powerful results than other approaches, yet this has been undervalued by funding. Low salaries at all levels of the organizations, expectations for CBOs to overdeliver for small amounts of compensation, and funding that does not support organizational capacity and development are limiting the growth of a promising field. **Funders have an opportunity to better align disbursements with stated values by supporting equitable compensation, power-sharing, and capacity building with community-based partners** (McGarvey & MacKinnon, 2008).

There have been some efforts made through federal grant programs to support CBOs, particularly in environmental health and community health. Funding for HIV treatment and prevention set one model for this approach in the 1980s, for instance by requiring the majority of funding to be used for contracting with CBOs representing or serving minority populations, and emphasized collaborative partnerships (Bailey, 1991). Capacity-building programs expanded in the late 1990s and early 2000s, including the investment of government funds in programs to build the capacity of potential not-for-profit partners. While relatively considerable resources were devoted to capacity-building programs, they did not conduct thorough evaluations to determine the extent to which such programs actually built capacity. Some of these efforts also focused on nonprofits with greater indicators of capacity in the belief that these organizations might have larger impacts on clients and constituents. However, there is some conflicting evidence that larger organizations may not be as effective at knowing and engaging populations experiencing the most inequities. Other federal funding directed to CBOs was designed to increase organizational capacity of nonprofit organizations engaged in programs and services, such as those supporting activities of the Department of Health and Human Services, the Department of Justice, and the Department of Labor. These initiatives provided funds for faith-based and community-based organizations to access capacity-building training, technical assistance, and financial assistance (Minzner, Klerman, Markovitz, & Fink, 2014). In another federal program, the National Institute of Environmental Health Sciences (NIEHS), together with the Environmental Protection Agency (EPA) and National Institute for Occupational Health and Safety (NIOSH), sought to increase collaboration between community residents, researchers, and health care providers to address environmental exposures. Over 13 years, NIEHS funded 54 environmental justice projects. Data gathered from these grantees found that it increased community awareness and capacity and positively influenced public policy and community health factors. They found that **community participation was particularly important to implementing effective strategie**s (Baron et al., 2009).

Measuring the capacity of CBOs can be challenging. Minzner et al. (2014) reported that there did not seem to be a validated instrument for measuring capacity and developed their own instrument. Other evaluation and research efforts have also developed tools for assessing organizational capacity. De Vita, Morley, De Leon, Fyffe, and Pettijohn (2013) focused on questions of collaboration and partnership, organizational sustainability, value of capacity-building services, and lessons learned. Minzner et al. (2014) also **defined the following capacity-building categories from their research: organizational development, program development, revenue development, leadership development, and**

community engagement. It may also be important to look at the balance across areas of capacity, as some research has indicated that CBOs tend to focus on either internal (structure and efficiency) or external (funding and relationships) growth factors to the detriment of the other factors (De Vita, Fleming, & Twombly, 2001; De Vita et al., 2013). Development and implementation of the survey tool used in this project may contribute to future capacity assessments.

One article noted that the disproportionately low levels of power conceded to communities of color result in disproportionate environmental exposures that create urban and rural "riskscapes." When decision-making structures and processes amplify power inequities, it results in the uneven distribution of infrastructure and of environmental amenities and hazards. From this perspective, environmental health interventions will need to focus more on structural inequities and not just on immediate impacts and outcomes. To better understand this approach, researchers analyzed the factors that contributed to community capacity to participate in making environmental decisions and interventions to support this capacity. In this analysis, community capacity, authentic participation, and democratic power were considered critical tools for altering structural and environmental causes of health inequities. Three levels of intervention opportunities were named: preventing exposure to stressors through policy, plans, or practice; strengthening community capacity through training, technical assistance, or organizing; and moving to more authentic and inclusive community participation approaches in environmental decision-making. The key values to this approach were **"engage early, address power, define the relationship"** (Freudenberg et al., 2011). This research also identified six key intervention strategies to increase community capacity, which were explicitly explored with the CBOs in the survey and interview process:

- "Training and technology transfer: Process by which community participants gain knowledge, skills, competencies, or technologies that enable them to participate in assessing and remediating environmental hazards and participating in relevant policy deliberations.
- "Technical assistance: Tailored support that enables community participants to gain information or skills to solve problems or to participate more effectively in decision-making processes.
- "Community-based participatory research: A research process in which community residents participate in selecting issues, designing studies, interpreting findings, and presenting results to policymakers for the purpose of reducing environmental health inequities and promoting healthier public policies.
- "Empowerment approaches: Process by which individuals, communities, and organizations gain power and mastery over their lives in the context of changing their social and political environment to improve equity and quality of life.
- "Community organizing/social action: Community mobilization and organization to enable a disadvantaged segment of the population to make demands on the larger community for increased resources and more equitable policies.
- "Authentic participation processes: Agency designed participation processes that improve community capacity by getting people involved early, providing them with information and resources for full participation, and ensuring that outcomes reflect their participation" (Freudenberg et al., 2011).

Some specific tools and approaches to incorporate health justice into infrastructure planning are becoming more widely available. Community-engaged planning as described through CBO leadership and/or CBPR partnerships is one approach. HIAs are another tool that has been used effectively to

increase the use of human and environmental health evidence, community health metrics, and community and stakeholder input into projects, plans, and policies (Dannenberg et al., 2008; Rhodus, Fulk, Autrey, O'Shea, & Roth, 2013). HIA is "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects" (National Research Council, 2011). After the COVID-19 pandemic, the challenges and opportunities for both infrastructure planning and community engagement may have transformed in unpredictable ways, including changing perceptions of communities and infrastructure, increased awareness of public health and health inequities, and new levels of economic hardship.

CONCLUSION AND NEXT STEPS

Infrastructure and planning decisions are most often made with a narrow focus on a single project or plan, within a single sector, and with minimal and unequal opportunities for input from the people and communities whose well-being will be impacted by them. This encompasses not just environmental exposures but also the social, psychological, and behavioral effects of environmental hazards through stress, disinvestment, discrimination, and more. There are two main, interconnected strategies to transition to planning and development that create environmental justice and health equity. One is transformed planning and policymaking practices within agencies in order to integrate stakeholder input. The second strategy is investment in community participatory capacity through transformational public and private funding for representative CBOs.

As discussed in the evidence review above and explored through interviews and survey, core capacity-building and engagement approaches have been identified and can be implemented in order to support the role of CBOs in facilitating stakeholder participation in the policymaking process. These strategies were training and technology transfer, technical assistance, community-based participatory research, community organizing/social action, authentic participation processes, and empowerment. These activities can be designed into planning and engagement stages of public initiatives as subawards to CBOs or to academic-CBO partnerships as described above. They can also receive direct investment from foundations or other private funders using a pipeline approach to routinely assess capacity and support access to technical assistance, mentorship, and other resources based on the results.

In either type of investment, the organizational and funding accountability and structure need to set project goals and strategies in a collaborative relationship and reward indicators of good collaboration such as trust, time taken to build relationships, mutual understanding, aligned goals, power and resource sharing, and capacity growth. Funders must avoid creating a hierarchical structure in which goals, activities, and deliverables are predetermined by the funder. Instead, a mutual agenda and shared values need to be cocreated between the CBO and the funding organization. Funders must also be careful not to perpetuate the tendency to expect that they can underpay CBOs and their staff, relative to performance, expertise, and output. Rather, they should expect to invest more into the operations of smaller or less established organizations, or those that are formed from communities that experience multiple inequities, in order to support essential administration, infrastructure, and engagement that can be more distributed across people and projects in larger organizations. Knowledge, values, and belief differences must be reconciled or at least managed; trust must be built. Support efforts need to be customizable, including personalized technical assistance, mentoring, and peer learning with other CBOs.

This project provides actionable steps to promote environmental health justice, within Georgia and other places. To follow up on the conference session, tour and networking event, and survey of organizations, it is recommended to hold a multisectoral meeting to present and discuss the results and convene the community of practice (COP). Participants in each phase of the project can form the core of this event and the COP, as well as their key partners and funders. The COP can facilitate more routine and participatory collaboration across health, environment, transportation, and community stakeholders using the strategies described herein to center equity in decision-making practices. One charge of the COP will be to institutionalize this transformation to create structures around data transparency, education to prepare citizen-scientist and community leadership, and accountability measures to ensure that the practices remain authentically centered in communities and provide equitable participation.

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APPENDIX A: INTERVIEW QUESTIONS

Part 1: General Information

1 Please list your name.

2 What is your title within the organization?

3 What organization do you represent?

4 In what year was the organization registered with the Georgia Secretary of State as a nonprofit, charitable organization?

5 How many paid full time and part time staff does the organization have?

Full time staff_____ Part time staff_____

6 Approximately how many volunteers work with the organization annually?

Volunteers_____

7 Roughly what is the organization's annual budget? (circle one)
Less than $100,000
$100,000 to $500,000
$500,000 to $1,000,000
Greater than $1,000,000

Part 2: Continuum of Growth

This survey envisions community-based organization on a continuum of growth. We seek to see to what extent it is better able to set and achieve its own goals on behalf of the community it serves as it becomes a more established organization.

1 What is the current level of organizational development within your organization? See the continuum shown on the diagram below. Where does your organization fall on this continuum? Please circle the appropriate number on the list below (where 1 represents being just getting started as an organization and 5 represents being a fully established non-profit organization.)

1 2 3 4 5

Levels	***Level of organizational development and interface with community members***
5	Community based organization is fully solidified with 501c3 status, functioning Board, assessment of strategic direction, some evaluation, and a platform for communication
4	Community based organization becomes further solidified through the addition of paid staff, some regular programming and funding
3	Community based organization becomes solidified with some structure and funding.
2	Residents coordinate their efforts through a Community Based Organization (CBO)
1	Residents act mostly on their own

2 What is the current level of power and engagement within your organization with reference to work with other health and equity partner organizations? Where is your organization on a second continuum based on the values shown on the second diagram? Please circle the appropriate number:

1: your community simply receives health or environmental health services from others;

2: your organization or your community is sometimes invited to partner with larger health organizations as they collect the data or you are asked to provide the feedback they request;

3: your organization or your community is always invited to partner with larger health organizations as they collect the data or you are asked to provide the feedback they request;

4: your organization has its own agenda and only sometimes allows larger health/environmental health organizations to engage them as partners to help you develop a strategy to take actions you believe will improve your community. See the second diagram below.

5: your organization has its own agenda and only rarely allows larger health/environmental health organizations to engage them as partners to help you develop a strategy to take actions you believe will improve your community.

1 2 3 4 5

Levels	*Level of Power and Engagement*
5	**Organization Has Set Priorities and Negotiates with Partner Organizations** Residents **in solid control of**: *Goal Setting; Planning; Implementation* CBO members have solidly decided their own priorities CBO invites multiple organizations to partner
4	**Organization Sets Some Priorities in work with Partner Organizations** *Residents **begin to gain control of** Goal Setting; Planning; Implementation* CBO members begin to decide their own priorities CBO may invite a few organizations to partner and be invited to partner by many
3	**Community Members as Participants/** **Organization as Advocate to Partner Organizations** Residents **participate in** *Goal Setting; Planning; Implementation* Potential partners invite residents to serve on governing body Potential partners invite residents to serve on advisory group CBO staff and residents serve as advocates for CBO
2	**Community Members as Information Sources to Partner Organizations** Residents are part of focus groups Other organizations consult with residents Residents fill out need surveys
1	**Community Members as Recipients of Partner Organizations** Residents receive services

3 What helps you as an individual to thrive? What do you think is most helpful in enabling your organization to thrive (i.e., move from one level on the continuum to the next)?

4 If you are at a level 3 or higher on either scale, what have been some of the events, trainings etc. that have particularly helped you move from a level 1 to your present level?

5 Have any of these specific practices been helpful to your group? If the practice has been helpful, please provide an example.

5.1 **Training** that has helped community members gain knowledge, skills, competencies that enable them to participate in assessing and remediating environmental hazards and participating in relevant policy deliberations.

5.2 **Technical assistance.** Tailored support that enables community participants to gain information or skills to solve problems or to participate more effectively in decision-making processes.

5.3 **Partnership/Collaboration in Community-based Participatory Research**. This is a research process in which community residents participate in selecting issues, designing studies, interpreting findings, and presenting results to policymakers for the purpose of reducing environmental health inequities and promoting healthier public policies.

5.4 **Community Organizing Assistance**. Community mobilization and organization to enable a disadvantaged segment of the population to make demands on the larger community for increased resources and more equitable policies.

5.5 **Resources for Stronger Participation**. Partner-designed participation processes that improve community capacity by getting people involved early, providing them with information and resources for full participation, and ensuring that outcomes reflect their participation.

6 Considering your experience with collaboration and partnership, list two things you found challenging? Ultimately, how did you overcome them?

7 What barriers have you encountered as you have sought to advance to a higher level on either scale?

Part 3 Planning

1. Have you formally collaborated or partnered with a government agency to engage communities to gather information, insights or community experience that would influence policy? If so, please describe the situation. What did you do? (for example collect data as directed by others, lead the project, plan with other stakeholders, assist in project implementation, advocate for specific policies based on recommendations)
    a. What did you learn in this process?

    b. What was the impact of this on your work?

2. Do you see value in these activities? Why or why not?

3. What do you think your organization needs in order to act in this role in the future, or expand your activities of this type?

4. Are there specific outstanding environmental health concerns in your community that your organization or the community itself has identified?

5. Have any Community Health Needs Assessments (CHNAs) been conducted for your community? Have any Health Impact Assessments (HIAs) been done for your community?

6. If a CHNA or HIA were completed, do you believe these assessments were helpful? How were they used? Was any action taken as a result of the recommendations made by these assessments?
7. Were any community members engaged in the completion of these assessments? If yes, what was particularly good about the engagement?

8. Do you believe that a sufficient number of members of the communities you work with understand environmental health concepts and issues? If not, who needs to know more? What would be the best ways to increase their environmental literacy?

9. Is there a need to conduct additional assessments? If so, what issue do you believe needs to be targeted?

10. What would you like funders to know as they develop Requests for Proposal and evaluate proposals so that they can better consider the realities on community-based organizations like the ones completing this survey?

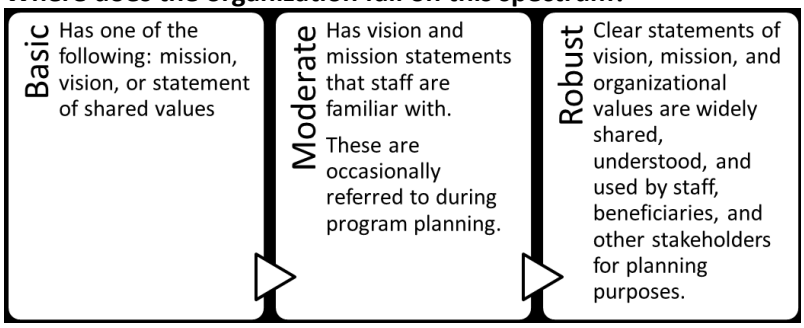
APPENDIX B: SURVEY QUESTIONS

Organizational Capacity Assessment for Community Based Organizations[1]

1. Vision, Mission, and Values

Rationale: Organizations that have articulated and shared what drives them and toward what they are working create a sense of shared ownership and common commitment to activities.

- **Please answer the following questions:**
  - Does the organization have a vision statement, mission statement, and statement of values?
  - Are the vision and mission used to set priorities? If so, please describe how.
  - Are these statements posted openly in the office or somewhere that staff and visitors can see?
  - Are the statement(s) used in human resource materials (i.e., staff handbooks, orientation materials, job descriptions, etc.), organizational brochures, reports, and proposals?
  - Does the organization regularly review the vision and mission statements (for example, in conjunction with strategic and/or operational planning)?
- **Where does the organization fall on this spectrum?**



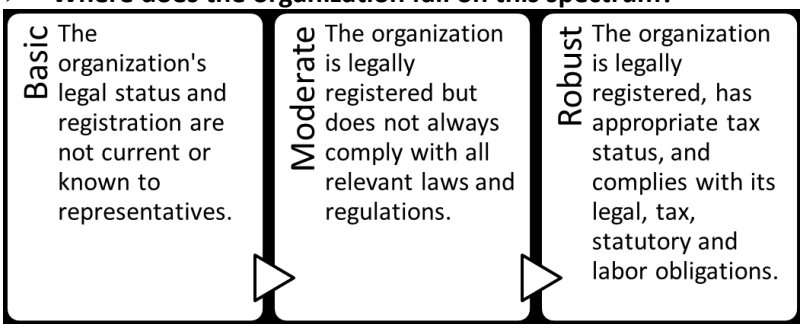
2. Legal Status

Rationale: Legal registration, as well as careful adherence to relevant tax and labor laws, enable an organization to gain recognition, perform functions like holding a bank account, and implement programs accountably.

- **Please answer the following questions:**
  - Is the organization legally registered and is the documentation of current legal registration readily available (or posted) in the office?
  - Are labor laws adhered to? Is this documented in human resource policies?
  - Does the organization submit annual state and Federal tax documentation for both itself and the staff?
  - Does the organization complete an annual audit?
  - Does the board review and approve the audit and other statutory reports?

[1] USAID, Organizational Capacity Assessment for Community-Based Organizations developed under New Partners Initiative Technical Assistance (NuPITA) Project, June 2012

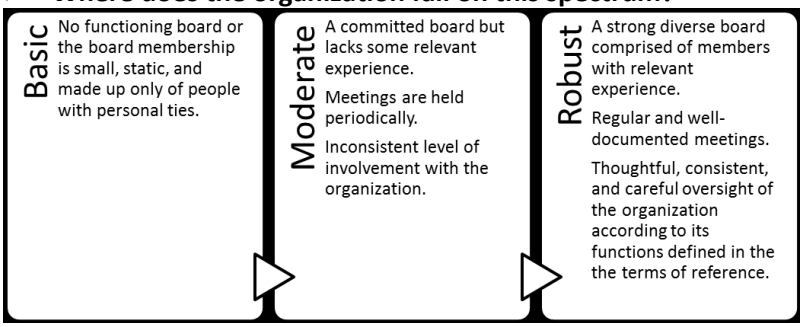
- **Where does the organization fall on this spectrum?**



3. Governing or Advisory Board

Rationale: Governing or advisory boards whose members are committed to the organization and bring relevant knowledge and experience provide guidance, support, and oversight to the organization's staff and operations.

- **Please answer the following questions:**
    - Does the board have approved Bylaws and Operating Principles that detail its primary duties?
    - Are board roles clearly differentiated from those of the staff?
    - Are there clear and documented criteria for becoming a board member?
    - Are there term limits and a system for electing or approving board members?
    - Are diversity and equity considerations in selecting board members?
    - Does the board meet regularly and document its decisions with minutes?
    - How are board members involved in strategic planning, resource mobilization, and developing and approving organizational policies and budget and annual financial statements?
- **Where does the organization fall on this spectrum?**



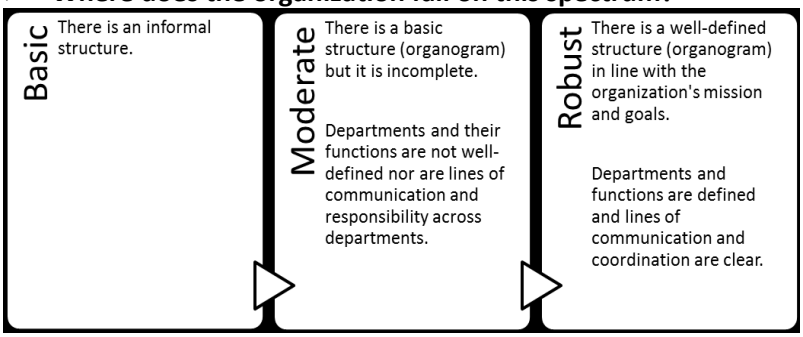
4. Organizational Structure

Rationale: An organization whose structure is in line with its mission, goals, and programs and has systems in place to ensure coordination among departments and functions can improve its efficiency and effectiveness.

- **Please answer the following questions:**
    - Is the organizational and reporting structure clearly documented and disseminated?
    - Is there an organization chart or other document outlining supervisory and staff responsibilities?

- How do departments communicate with each other and what are their functions?
- Does the current structure adequately support the departments/functions?

➢ **Where does the organization fall on this spectrum?**



5. Financial Policies and Procedures

Rationale: Having clear, well-documented policies and procedures for financial management that are understood and used by staff members allows an organization to function transparently and promotes integrity and accountability.

➢ **Please answer the following questions:**

- What type of accounting system does the organization use? How is the system implemented? Is the organization using accounting software?
- Which financial procedures are documented? How are financial procedures developed and approved? How often are the financial procedures formally reviewed/updated? What is included in the financial policies and procedures? Do they include:

o A signatory/authority matrix (who can do what)? Does it include authorization limits?
o Who are the organization's check signatories?

o Budgeting and reporting requirements?

o Policies regarding receipts (definition, recording)?

o Requirements for documenting expenses/payments and income/receipts (supporting documentation and retention period)?

o Managing bank accounts in the organization's name?

o Managing petty cash (who can spend, types of items, limit)?

o Monthly reconciliation of all cash accounts?

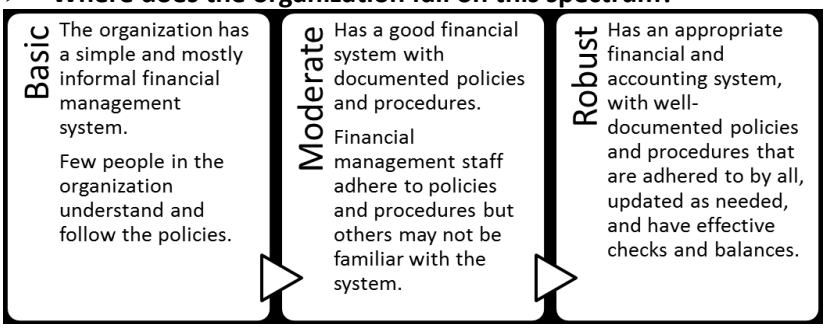
o Policies and procedures for handling potential fraud?

How are staff members oriented/trained in the procedures? How often?

- Does the organization have separate accounts for separate programs? Does the organization use codes to assign transactions to a specific project/donor?
- Is there a cashbook (or bank journal) completed in ink used for each bank account?

- How are account balances kept? Are all payments and receipts recorded in the organization's bookkeeping system? How are transactions in the accounting system linked to supporting documentation?
- What systems ensure compliance with financial procedures? At the end of the fiscal year how are accruals recorded?

➢ **Where does the organization fall on this spectrum?**



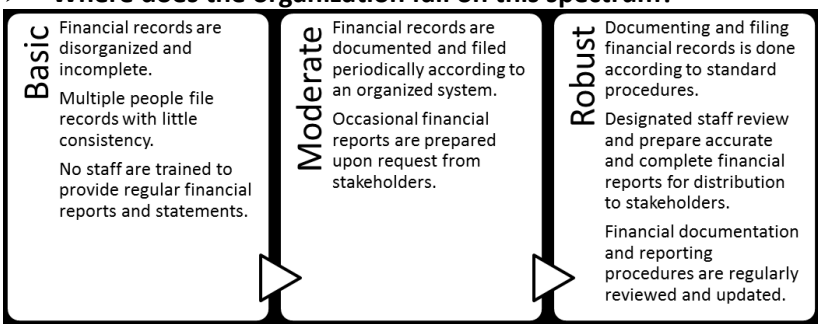
6. Financial Documentation and Reporting

Rationale: Keeping accurate and up-to-date financial records enables an organization to track resources, monitor its financial status, and prepare accurate financial reports for donors, stakeholders, and auditors in a timely fashion.

➢ **Please answer the following questions:**

- Are financial records maintained by volunteer staff, paid part time consulting staff or full time/part time permanent staff?
- Are there written guidelines and procedures for documenting all types of financial transactions?
- How often are these guidelines reviewed and updated? What is the process for this?
- Is the organization's financial documentation up-to-date?
- Are financial files kept neatly, organized, and secure?
- Are there procedures for preparing and disseminating financial reports?
- Who in the organization prepares, reviews, and approves financial reports that are shared with donors and other stakeholders?

➢ **Where does the organization fall on this spectrum?**

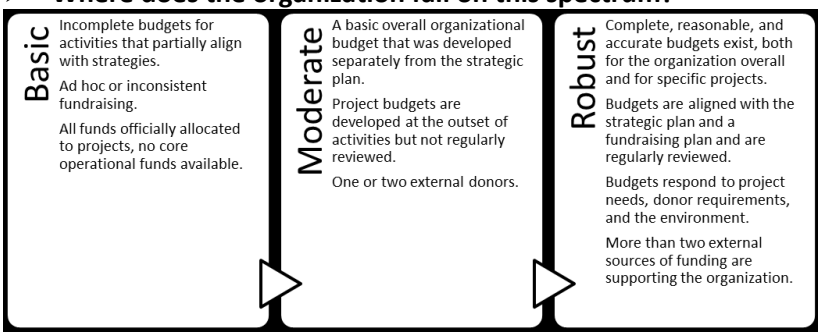


7. Financial Planning and Sustainability

Rationale: Financial planning and monitoring that aligns with program planning and monitoring enables an organization to implement planned activities and demonstrate accountability to resource

providers, which builds their confidence in the organization and makes them more likely to continue supporting the organization.

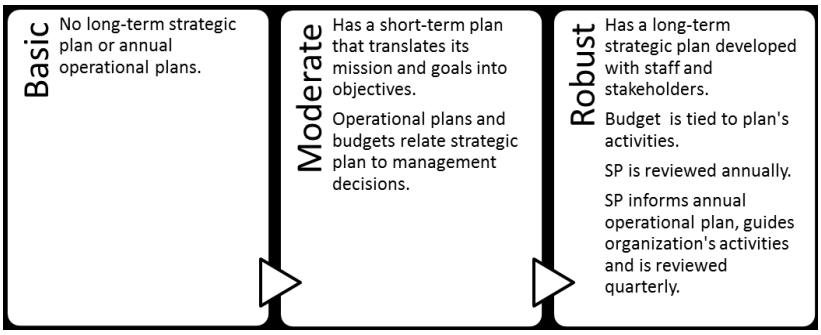
- **Please answer the following questions:**
    - Does the organization have a master budget that includes operating and overhead costs as well as project activities? How is it developed? How are budgets reviewed and approved? Are they frequently updated?
    - Are project budgets developed during activity planning?
    - Does the organization have a documented fund/resource development strategy? How does it relate to the strategic plan?
    - Does the organization have income-generating activities, fee-for-service income or other sources of unrestricted funding?
    - Does the organization have a cash flow that allows it to meet its financial obligations?
    - Is the organization in debt?
- **Where does the organization fall on this spectrum?**



8. Strategic and Operational Plan

Rationale: Having a strategic plan helps an organization realize its mission and goals with a shared vision, and both long-term plan, and annual operational plans.

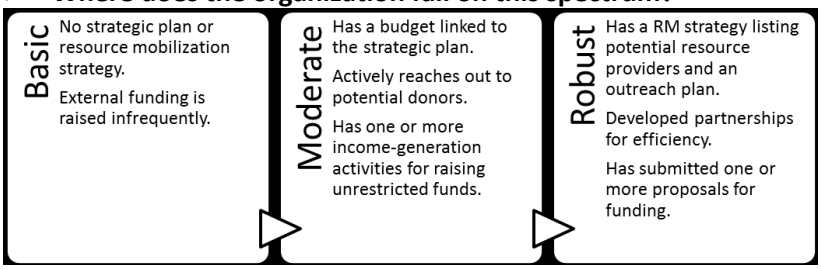
- **Please answer the following questions:**
    - Does the organization have a current strategic plan?
    - Did staff and stakeholders participate in its development?
    - Does it include measurable objectives, resource needs, and costs?
    - Is the strategic plan used to guide annual operational planning?
    - Is the operational plan linked to the budget?
    - How are the plans reviewed and monitored?
- **Where does the organization fall on this spectrum?**



9. Fund Development and Resource Mobilization

Rationale: A fund development mobilization plan that ties to the strategic plan's budget enables the organization to prioritize strategies for identifying and approaching appropriate donors.

- **Please answer the following questions:**
  - Does the organization have a strategic plan that identifies resource needs?
  - Have potential funders or donors been identified?
  - Is there a strategy for obtaining funds and resources to support program priorities?
  - Do staff or board members in the organization have the skills needed for proposal writing and communication strategy implementation?
  - Does the organization have income-generating activities or other sources of funds that are not tied to a single program but can support general operations?
  - Does the organization partner with other organizations to maximize input and minimize cost?
- **Where does the organization fall on this spectrum?**



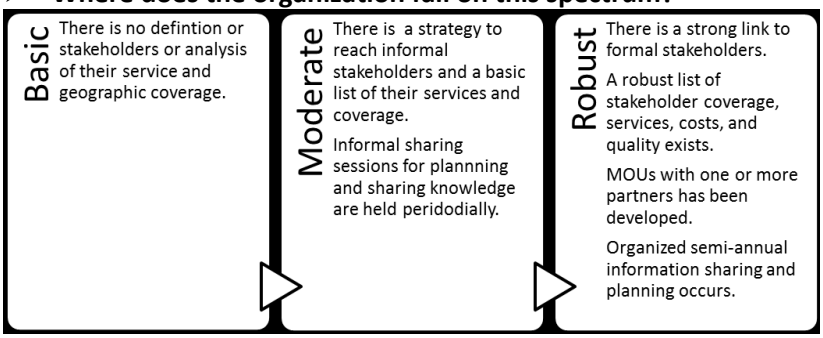
10. Stakeholder Involvement

Rationale: Identifying and nurturing relationships with relevant stakeholders can facilitate program coordination, partnering, and resource sharing.

- **Please answer the following questions:**
  - Does the organization have one or more stakeholder (partner) organizations with which it works regularly?
  - Does the organization have written MOUs or other collaborative agreements with relevant stakeholders?
  - Does the organization partner with stakeholders to pursue and implement both organization- and stakeholder-led projects?
  - Do the organization's core partners share its commitment to diversity and equity?

- Does the organization plan with and update relevant stakeholders (community, donors, districts, etc.) on progress?

➢ **Where does the organization fall on this spectrum?**



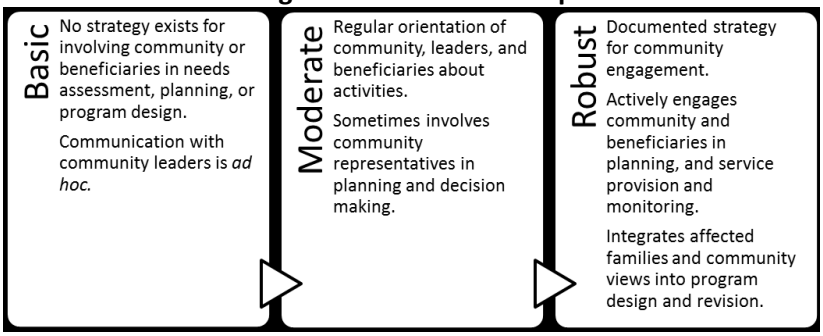
11. Community Involvement

Rationale: Involving the community in designing, monitoring, and implementing activities fosters buy-in and makes programs more relevant, effective, and sustainable.

➢ **Please answer the following questions:**

- Are the community, beneficiaries, and leaders involved in identifying needs and designing strategies? How?
- Are community members involved in prioritizing issues of concern?
- Does the community and/or beneficiaries assist in program activities or provide feedback? How?
- Does the organization provide regular updates on program results and solicit feedback from the community?
- Does the organization have tools to assess the diversity, equity and inclusion issues facing its communities? Does it incorporate the assessment findings into program design?

➢ **Where does the organization fall on this spectrum?**



12. Project Implementation

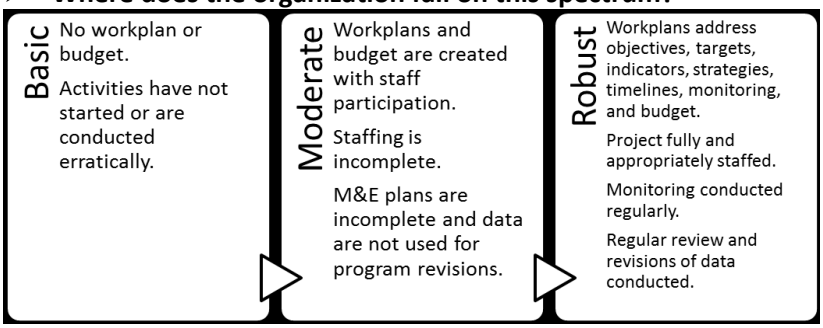
Rationale: Creating a detailed plan with objectives, targets, indicators, activities, and a timeline as well as appropriate staffing, budgeting, and continual monitoring makes it easier to implement, monitor, and revise projects.

➢ **Please answer the following questions:**

- Has a budgeted workplan document identifying key project activities been developed for each project?

- Was it developed with input from staff?
- Are activities taking place according to the workplan timeline?
- Are there people (staff/volunteers) in place with the required skills to implement the activities?
- Is there a monitoring plan? Are the data reviewed regularly?
- Are revisions to the project made based on the data?

➢ **Where does the organization fall on this spectrum?**



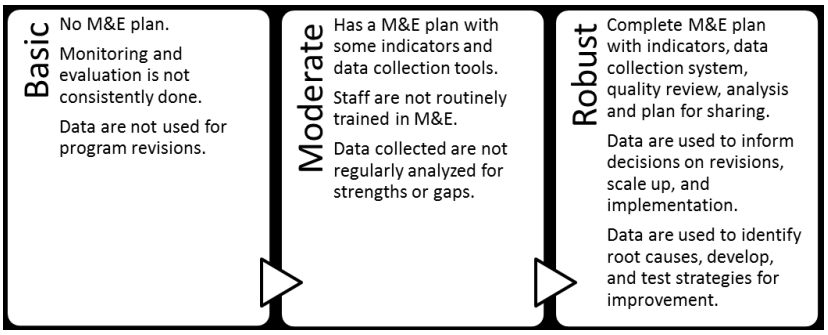
13. Monitoring and Evaluation (M&E) and Quality Assurance (QA)

Rationale: Collecting, analyzing, and reviewing data on project activities and beneficiaries helps organizations identify strengths and gaps and review whether they are achieving targets. Setting up a quality assurance process allows activities to design and test strategies for achieving performance standards.

➢ **Please answer the following questions:**

- Is there a monitoring and evaluation (M&E) plan for each project? Does it include output and outcome indicators, data collection tools, quality review, and plans for sharing and using data?
- Is M&E training provided to relevant staff including providers, data collectors, and supervisors?
- Are M&E data routinely collected, analyzed and discussed with management, staff, stakeholders, and the community?
- Are the data used to improve performance?
- Are the data used to identify quality challenges and root causes?
- Does the organization develop plans to address the challenges, test results, and implement effective practices?
- Is the organization aware of the measurable impacts of their programming and able to share this with community members, stakeholders and funders?

➢ **Where does the organization fall on this spectrum?**


Basic
No M&E plan.
Monitoring and evaluation is not consistently done.
Data are not used for program revisions.
Moderate
Has a M&E plan with some indicators and data collection tools.
Staff are not routinely trained in M&E.
Data collected are not regularly analyzed for strengths or gaps.
Robust
Complete M&E plan with indicators, data collection system, quality review, analysis and plan for sharing.
Data are used to inform decisions on revisions, scale up, and implementation.
Data are used to identify root causes, develop, and test strategies for improvement.