A mixed-method evaluation of the New York State Eat Well Play Hard Community Projects: Building local capacity for sustainable childhood obesity prevention

Kaydian S. Reid, Jackson P. Sekhobo, Leigh A. Gantner, MaryEllen K. Holbrook, Marie Allsopp, Linda B. Whalen, Amy Koren-Roth

A U niversity at Albany School of Public Health, State University of New York, United States
b Division of Nutrition, New York State Department of Health, United States
c College of Human Ecology, Cornell University, United States

A R T I C L E   I N F O

Keywords:
Community coalitions
Childhood obesity prevention
Capacity building
Technical assistance
Mixed methods
Policy, system, and environmental (PSE) changes

A B S T R A C T

This study used a mixed-method, comparative case study approach to assess the level of capacity built for childhood obesity prevention among seven New York State Eat Well Play Hard–Community Projects (EWPH-CP). Data were collected through a self-reported survey in 2007, semi-structured interviews in 2009, and EWPH-CP program documentation throughout the 2006–2010 funding cycle. Quantitative and qualitative analyses were used along with an integrative framework for assessing local capacity building to characterize the capacity built by the study coalitions. Four coalitions rated membership characteristics as a challenge at the beginning of the funding cycle. Towards the end of the funding cycle, all seven coalitions reported activities that were initially focused on building their membership (i.e., member capacity) or positive working relationships (i.e., relational capacity), before eventually pursuing support and resources (i.e., organizational capacity) for implementing their chosen community-oriented programmatic goals (i.e., programmatic capacity). Five coalitions reported environmental changes aimed at increasing physical activity or fruit and vegetable intake. Technical assistance provided to coalitions was credited with contributing to the achievement of programmatic goals. These results suggest that the coalitions succeeded in building local capacity for increasing age-appropriate physical activity or fruit and vegetable intake in the target communities.

1. Introduction

Collaborative partnerships in public health, such as community-based coalitions, attempt to improve conditions and outcomes related to the health and wellbeing of entire communities (Roussos & Fawcett, 2000). Specifically, community-based coalitions that comprise of professionals and grassroots leaders seek to create alliances that promote health and wellness in communities via policy, systems, and environmental (PSE) changes. This strategic approach has been used to promote a wide variety of health outcomes, beginning in the 1980s and 1990s when the emphasis in public health prevention shifted to local communities working to solve local problems (Roussos & Fawcett, 2000; Shortell et al., 2002). Community-based coalitions are often emphasized by funders and lauded in the public health community because it is anticipated that efforts based in community priorities and executed by community members are more likely to be adopted and possibly maintained (Frieden, 2010; Kegler et al., 2015; Leeman et al., 2012; Lieberman, Golden, & Earp, 2013; Merzel & D’Afflitti, 2003; Okubo & Weidman, 2000; Sallis, Owen and Fisher, 2008). Community capacity building enables coalitions to identify problems and then to mobilize and address them collectively (Wallerstein, Minkler, Carter-Edwards, Avila, & Sanchez, 2015). In addition, community-based coalitions set the foundation for PSE changes that emphasize population-level health focus which offer sustainable support for behavior change (Kegler et al., 2015; Lieberman et al., 2013; Sallis et al., 2008) rather than individual-level health focus which are known to have limited sustainability (Frieden, 2010; Leeman et al., 2012). Childhood obesity prevention requires a consortium with diverse skills and resources representing many sectors and stakeholders (Huang, Drewnowski, Kumanyika, & Glass, 2009). It is not surprising, therefore, that innovative childhood obesity interventions have called for multi-level, multi-sectoral approaches that include use of community coalitions to address the complex web of factors contributing to the epidemic. Local capacity building is the focus of community coalitions and is
characterized by an increase in community groups’ capabilities to collectively define, assess, analyze, and act on a health concern pertinent to their community (Labonte & Laverack, 2001). For example, the state of Arkansas has successfully responded to its childhood obesity epidemic by supporting community coalitions that brought together stakeholders from different sectors and led to collaborative activities focused on combatting the state’s childhood obesity epidemic (Centers for Disease Prevention and Control, 2012). Similarly, community coalitions affiliated with the Healthy Kids, Healthy Communities program in California, focused on building capacity for community members to participate in identifying a priority community improvement focus problems, engage in coalition activities, and increase input into local decision-making (Kegler, Norton, & Aronson, 2007).

Despite the successes of local community-based coalitions’ use of capacity building for prevention and health promotion for childhood obesity, challenges exist. A review by Kreuter, Lezin, and Young, (2000) documented that many coalitions struggled with organizational or systems-level change, even among successful coalitions. This is because too many factors beyond the control of coalition members in creating these organizational and societal level changes manifest among coalition members (Kreuter et al., 2000). For example, coalition members in the California Healthy Cities and Communities program identified two areas of skills (i.e., community problem-solving skills and collaboration skills) that needed to improve in order to increase community capacity building. A multiple case study design (Alexander, Christianson, Heald, Hurley, & Scanlon, 2010) identified four common capacity building challenges coalitions experience: 1) specifying appropriate governance structures and decision-making frameworks, 2) aligning stakeholders’ interests with the vision of the coalition, 3) balancing short-term objective with long-term goals, and 4) securing resources to sustain the effort without compromising it. Thus, identifying and addressing the shortcomings of community-based coalitions is inherently an important intermediate step for building local capacity for PSE changes (Kreuter et al., 2000; Zakocs & Guckenburg, 2007).

The role of State Health Departments in building local capacity for community-based childhood obesity prevention is essential since the departments often provide funding, training, and technical assistance that address coalitions’ shortcomings. Specifically, State Health Departments may play a role in ensuring that coalition capacity building occurs within members, within relationships, within their organizational structure, and within the program they sponsor to be better detected with more effective evaluation tools and over longer time horizons. In New York State, two initiatives, namely Eat Well Play Hard and Creating Healthy Places to Live Work and Play, have been implemented as collaborative efforts to prevent childhood and adulthood obesity through community-based coalitions. This process evaluation uses an integrated capacity building framework developed by Foster-Fishman, Berkowitz, Lounsbury, Jacobson, and Allen (2001) to assess whether and how community-based coalitions funded under the New York State Eat Well Play Hard Initiative (Jesaitis & Race, 2000) from 2006 through 2010 built capacity for PSE changes to prevent childhood obesity in their communities.

2. Methods

2.1. Program description

Eat Well Play Hard Community Projects (EWP–CP) were part of a statewide childhood obesity prevention program initiated by the Division of Nutrition, New York State Department of Health (NYSDOH), in the late 1990s following evidence of increasing prevalence of obesity among children enrolled in the WIC program (Jesaitis & Race, 2000). County health departments and community-based organizations applied for EWP–CP grants and were awarded funding during three funding cycles (i.e., 1998–2003, 2003–2006, and 2006–2010) to support community-based partnerships and build local capacity for childhood obesity prevention in different parts of the state. The first cycle focused on promoting awareness of childhood obesity and covered the period from July 1, 1998 to June 30, 2003. The second cycle covered the period from July 1, 2003 through September 30, 2006 and focused on building capacity for program implementation. The third and final funding cycle focused on building capacity for program implementation via PSE changes beginning on October 1, 2006 through September 30, 2010. This last round of funding consisted of 15 coalitions covering 22 counties and is the focus of this process evaluation.

Briefly, each of the 15 EWP–CP contractors (i.e., coalitions) was expected to use community-based partnerships and coalitions to build capacity for childhood obesity prevention. Each EWP–CP coalition had a local EWP–CP coordinator. The coordinators were expected to create partnerships with local stakeholders from a wide range of backgrounds with interest in promoting obesity prevention initiatives in their community. These partnerships consisted of a core group of individuals working to assess, plan, and implement projects in funded communities. In addition, regional NYSDOH contract managers oversaw the contracts and provided ongoing technical assistance. All EWP community projects were to go beyond traditional health education approaches to obesity prevention and aim to create PSE changes. The PSE changes were to be implemented in pursuit of at least one of the following three strategies: 1) increase age-appropriate physical activity, 2) increase consumption of low-fat/fat-free milk, and 3) increase consumption of vegetables and fruits.

2.2. Theoretical framework

Based on a critical review of 80 articles, chapters, and practitioners’ guides focused on collaboration and coalition functioning, the integrated framework developed by Foster-Fishman et al. (2001) outlines the core competencies and processes needed to promote successful community coalitions. The framework consists of four levels of collaborative capacity, namely: member capacity, relational capacity, organizational capacity, and programmatic capacity. Member capacity refers to the ability of members to perform needed tasks and to work collaboratively together; a coalition’s membership is considered its key asset and many coalitions devote time and resources to recruiting capable members. Relational capacity constitutes the second level of capacity and refers to the ability to develop social relationships needed to achieve the coalition’s goals; effective collaboration requires members to interact among themselves and with external stakeholders in expanded and improved ways. Building upon the prior levels of capacity, organizational capacity is indicated by the presence of a strong leadership base, formalized processes and procedures, an internal communication system, human and financial resources for performing the collaborative work; coalitions that have a growth-mindset are more successful in achieving their goals. Programmatic capacity is the fourth and final level of capacity and denotes the capacity to guide the design and implementation of programs that address community needs and build on identified community strengths; coalitions can play a direct or catalyst role in the implementation of programs.

2.3. Study design

The process evaluation used a mixed-method, multiple case study approach to assess the level of capacity built among seven EWP–CP community projects during the 2006–2010 funding period. The study communities were selected based on four criteria: 1) implementation settings (e.g., school, community, daycare), 2) training and background of the coordinator (e.g., public health, nutrition/dietetics, or community organizing background); 3) geographic setting (e.g., regions of the state, urban/suburban/rural); and 4) partnership structure and function (e.g., centralized decision-making vs. individualized decision making) (see Supplementary Table S1). For the partnership structure and function scoring, coalitions completed Wilder Collaboration 20 Factors...
دریافت فوری
متن کامل مقاله

امکان دانلود نسخه تمام متن مقالات انگلیسی
امکان دانلود نسخه ترجمه شده مقالات
پذیرش سفارش ترجمه تخصصی
امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
امکان دانلود رایگان ۲ صفحه اول هر مقاله
امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
دانلود فوری مقاله پس از پرداخت آنلاین
پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات