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An Examination of the Complexity of Power and Race when a Predominately White Institution Partners with Black Communities to Address Infant Mortality

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ABSTRACT

Using quantitative and qualitative thematic analysis from an evaluation survey and intensive interviews from the Lifecourse Initiative for Healthy Families (LIHF), this article explores the unequal power dynamics between academic and community partners in an initiative that addresses disparities in Black infant mortality in Southeastern Wisconsin. Initiated and funded by a public health endowment fund at the University of Wisconsin-Madison School of Medicine and Public Health(UW-SMPH), LIHF began in 2009 in Beloit, Kenosha, Milwaukee, and Racine, Wisconsin. LIHF is a multi-year community-academic partnership which included community-based planning, establishment of funded and centrally supported community collaboratives, and 1–3-year project grants. Survey and interview respondents revealed that many Black community members and academics perceived white academic partners as avoiding addressing root causes of systemic racism, maintenance of structural power imbalances, and how these disparities are related to the very long history of racism and disparities throughout the state. The white respondents (mostly) saw a lack of willingness and/or capacity for the Black community partners most vocally involved to effectively deal with the policy, systems and environments that contributed to the disparities. This was further hampered by the structure of the initiative which seperated the fiscal and administrative control from implementation. Evaluation participants expressed concerns regarding the structure of the Initiatives which failed to center the voices of those most impacted. Evaluators concluded that if the community and academic partners are interested in making long-term impacts, they will have to let go of traditional ways of community-academic collaborations and begin to embrace future possibilities to more effectively impact communities of color.

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INTRODUCTION

Facing consistent and dramatic disparities for Black infants and mothers, the Wisconsin Partnership Program (WPP) committed millions of dollars to the Lifecourse Initiative for Healthy Families (LIHF or "the Initiative"), a multi-year community-academic collaboration created to work toward reducing this disparity in infant mortality (Frey et al., 2014). Community members throughout southeast Wisconsin were excited that funding had been committed to an initiative focused on Black health disparities; stakeholders stated that this level of investment rarely focuses solely on Black people or Black issues. Because of this complex history, Black community leaders and stakeholders wanted to ensure that they were involved in every component of LIHF, including decision-making and leadership.

This article summarizes the views of stakeholders of all races/ethnicities who were interviewed as part of the LIHF summative evaluation. Most interviewees had concerns about the deep influence and structure of power dynamics regarding race and racism within the Initiative. Although Black stakeholders were initially invited to discuss strategies, after the Initiative began, their input and contributions were not valued as highly as those of the predominantly white academic leadership, causing resentment and contributing to both perceived and measurable lack of impact on desired outcomes. We explore these dynamics and suggest mechanisms to effectively center the voices of those most impacted to advance health equity.

BACKGROUND

In 2018 and 2019, the University of Wisconsin-Madison Population Health Institute (UWPHI) completed a summative evaluation of a 10-year multi-level initiative whose goal was to reduce disparities in infant mortality and improve healthy birth outcomes among Black women who live in southeast Wisconsin. In Wisconsin, Black infants are nearly three times more likely to die before their first birthday than white infants (Wisconsin DHS, 2019). LIHF was a multi-year community-academic collaboration created to address this issue and work toward reducing this disparity in infant mortality (Frey et al., 2014). The Initiative began in 2009 in the cities of Beloit, Kenosha, Milwaukee, and Racine, Wisconsin. The UWPHI's evaluation included analysis of vital statistics and data from the Pregnancy Risk Assessment Monitoring System (PRAMS) (CDC, 2019) surveys of new mothers, surveys of constituent groups in communities and the university, and intensive interviews with key stakeholders (Moberg et al., 2019).

EVOLUTION OF THE LIHF INITIATIVE

The power dynamics described below are best understood with some context about the Initiative's origins and how it evolved over its roughly 10-year time span. LIHF grew out of the recognition of and sense of urgency to address the huge disparities in Black infant mortality in Wisconsin. The Dean of the University of Wisconsin School of Medicine and Public Health (UW SMPH) championed the Initiative and directed funds from the WPP endowment administered within the school toward this effort. These funds were endowed to the SMPH by an agreement that allowed the conversion of a nonprofit health insurance company (Blue Cross-Blue Shield) to a for-profit corporation (Kittle, 2018).

The WPP sponsored and managed LIHF, which included funding of community-based planning, the funding of 23 specific project grants, and local collaboratives in four communities (Beloit, Kenosha, Milwaukee, and Racine). During the planning phase, there were contracts with community agencies to convene local partners to plan and develop Community Action Plans (CAPs). WPP leadership emphasized that CAPs should focus on approaches that address social and structural determinants of health and health disparities in Black-white birth outcomes, an approach championed most notably by Dr. Michael Lu and other maternal and child health epidemiologists and providers (Lu et al., 2010). After the CAP planning phase, WPP funded and supported community collaboratives to convene with local partners to spread awareness of Black infant mortality, develop and implement strategies for communities to address the disparities in birth outcomes, and to identify and address policies, systems, and environments that were contributing to the disparity. The concept of collective impact (Kania & Kramer, 2011) was introduced to guide interactions between LIHF collaboratives and other community public health initiatives.

The project grants funded community organizations with the expectation that they would implement specific recommendations identified by the CAPs in consultation with an academic partner. The project grant recipients were expected to participate in their local community collaboratives but had no direct reporting relationship or responsibility to the collaboratives. Additionally, the WPP established a LIHF Program Office to provide technical assistance and monitor the LIHF collaboratives, individual evaluation plans, activities, and regional strategies. The LIHF model is further described in Frey et al. (2014); Cotton et al. (2019) provides a structural analysis and case study of the implementation of LIHF.

POWER DYNAMICS OF RACE AND RACISM

This article focuses on how key participants viewed power dynamics of the initiative, comparing the perceptions of Black and non-Black stakeholders. The juxtaposition

of Black voices to non-Black voices is central and Black stakeholder voices are centered since the initiative is focused on the health of the Black community. Most stakeholders posited that the unequal power dynamics pertaining to race and racism created challenges within the Initiative. More specifically, Black stakeholders in survey and interviews stated that non-Black stakeholders within this initiative failed to address the role that they played in racism, health disparities, and the power dynamics throughout the project.

METHODS

RACIAL DYNAMICS AND POSITIONALITY

Black stakeholders throughout this initiative encouraged the WPP and the LIHF Program Office to hire a Black program evaluator familiar with the racial and power dynamics between Madison and Milwaukee, Racine, and Kenosha and who had experience conducting culturally responsive evaluations (Hood et al., 2015). For most of the duration of the Initiatives, the evaluation team was white, with one Asian evaluator for a period of time. Taking a step to address this lack of representation, in April of 2018 the Population Health Institute hired Troy M. Williams, a Black program evaluator who had experience conducting research for community-based organizations but who was unfamiliar with the regionally unique power and racial dynamics that many of the stakeholders described.

All of the authors were evaluators working at an academic institute at a large research university located one to two hours' drive from the LIFH communities. The LIHF lead evaluator (AG) is a mid-career white woman with experience evaluating community-based programs and researching racial and ethnic disparities in health. The LIHF Evaluation's Principal Investigator (DPM), a white man, had over 40 years of experience evaluating community-based programs through both quantitative and qualitative methods. Sadly, Dr. Moberg passed away after this manuscript was submitted. A supporting author and evaluator, AWF, is a white woman with academic training in applied anthropology and public health and experience in community education settings.

EVALUATION DESIGN

This evaluation used a mixed-methods approach with an explanatory design that incorporated multiple stakeholder perspectives to better explain results from surveys and other quantitative data (Creswell & Plano Clark, 2007). A web-based survey of LIHF Stakeholders was conducted in the summer of 2018 to obtain broad structured feedback regarding the Initiative. This article draws on data from the quantitative and qualitative responses from the online stakeholder survey (n = 132) and follow up interviews with key informants (n = 25).

SAMPLE AND DATA COLLECTION

The online stakeholder survey was developed by the evaluation team in consultation with the LIHF evaluation working group. The working group included representatives from the LIHF Program Office (majority white, academic), the collaborative convening agencies (majority Black, non-profit organizations and community), and the funding agency (majority white). The working group reviewed and discussed the goals of the evaluation, multiple drafts of the survey, and early results and data interpretation. Stakeholders were identified by the working group and included collaborative members, public health professionals, health care professionals, community members, and others who had past and present involvement with the Initiative. Once the questions were finalized, the survey were sent to all the email addresses submitted (n = 461) via a web-based survey platform in late spring 2018 with several reminder/thank you emails.

The survey mostly consisted of questions that used Likert-type scales but also contained open-ended questions included to gain context related to the closed-ended questions and additional topics (e.g., "What were LIHF's most significant successes?"). Survey topics included access to healthcare; collaboration; LIHF events; community engagement; funding of the Initiative; and racism and representation in LIHF's leadership, community collaboratives, and priorities. After the survey closed, 132 responses were included in further analyses.

Intensive qualitative interviews were conducted in person for a separate purposively selected sample (n = 25) of key stakeholders. A list of potential interviewees was developed by the evaluation team and the LIHF Program Office, and the final selection of interviewees was made by the evaluation team to protect the identity of respondents. Interview participants were categorized into five groups based on their role in the grant: seven university affiliates, eight program staff, five project grant recipients, six community leaders, and two collaborative members. There was some overlap between categories; some individuals had multiple roles sequentially or simultaneously in the Initiative, so the 25 interviewees worked in 27 different roles throughout the Initiative. The respondents represented all LIHF communities and persons whose roles cut across the four communities: two Beloit, five Kenosha, nine Milwaukee, two Racine, and seven who worked across all sites. Of the 25 interviewees, 19 identified as Black and six identified as non-Black.

The evaluation team developed the interview guide after reviewing preliminary quantitative and qualitative survey results (e.g., open-ended responses to "What would you consider to be the strongest qualities of the initiative?"). The interviewers used a semi-structured guide to ensure that all desired content was covered while remaining open to the lived experience and thoughts of the participants (DiCicco-Bloom & Crabtree,

2006). Recruitment for interviews emphasized that this evaluation was trying to understand how the Initiative was implemented and that participants' views of the program would assist with the future planning of the Initiative. This evaluation used a culturally-responsive approach and the interviews were primarily arranged and conducted by an evaluator on our team that identifies as Black and has community-based organization experience (TMW). Interviews took place between July and October of 2018, were recorded with the verbal consent of the interviewees, and were transcribed for analysis by a professional transcriptionist. Evaluators communicated with participants via email to arrange meetings in locations that were convenient for interviewees, then drove to sites (e.g., coffee shops, jobs, hotel lobbies, offices) throughout the state to accommodate the participants. These procedures allowed for a faithful representation of the stakeholder's opinions reproducible in their own words and we uphold the stakeholders' voice by using extensive direct quotations to illustrate findings. Interviewees who were not employed through the Initiative were compensated for their time.

DATA ANALYSIS

The analysis of the survey and interview responses was a lengthy and complex process. Evaluators ensured that the LIHF evaluation working group was active in the analysis to improve the quality of the evaluation and illuminate the process for all parties involved. Quantitative analyses include comparisons of Black and non-Black respondents to survey items to highlight differences between the Black community and non-Black members of this Initiative who were considered to have more numerical and political power within the structure and success of the Initiative. Chi-square tests for independence and a two-sample t-test were used to identify survey items with significant ($p < .05$) differences between Black and non-Black respondents. Note that both Black and non-Black respondents represented academic and community-based stakeholders.

Analysis for open-ended survey responses and interviews was conducted using thematic analysis, a qualitative method that identifies, analyzes, and reports patterns throughout the data (Braun & Clarke, 2006). Open-ended survey responses and interview transcripts were imported into and analyzed with MAXQDA 2018.1, a software package designed to manage the organization and analysis of textual data. The survey and interview data were coded by two evaluators separately (TMW, AWF) and confirmed by a third (DPM). The evaluators read each open-ended response and categorized emerging themes. The four-person evaluation team met weekly to discuss themes and analysis and reviewed at least 10% of transcripts collectively to create a reliable, collaborative, iterative process of data analysis. Early results were reviewed and further refined by the LIHF evaluation working group.

RESULTS

QUANTITATIVE SURVEY

Table 1 shows results for select individual survey items. Overall, 91% of respondents thought that Black infant mortality was a very or extremely significant issue in their community. For most processes or components of LIHF such as overall leadership, membership in their collaborative, and leadership of their collaborative, just over half of respondents perceived that Black participants were very or extremely equitably or meaningfully involved. However, about two-thirds of respondents did not think that LIHF incorporated the assets and strengths of the Black community into its strategies or actions. There were few significant differences in perceptions between Black and non-Black respondents. Black respondents were more likely than non-Black respondents to perceive Black infant mortality as an "extremely significant" issue but over half of Black respondents saw Black involvement in leadership or decision-making of the collaborative to be not at all, a little, or somewhat involved, a significantly lower perception of Black leadership than perceived by non-Black respondents. There were no significant differences in perceptions on items addressing Black involvement in the overall leadership of the Initiative, equitable and meaningful membership of the collaboratives, developing community action plans, involvement in community project grants, planning collaborative work, and strengths of LIHF as a leader in efforts to improve Black infant mortality.

We also examined items related to successes of the initiative in achieving its primary stated goals for the 10-year program (Table 2). The overall perceptions of success in reducing Black infant mortality and disparities in mortality and in improving the health of Black mothers and infants were modest and did not differ between Black and non-Black respondents. While not shown in the table, there was no significant difference in perceptions of success on any of the areas' recommended lifecourse topics and social determinants of health areas for reducing Black infant mortality (Lu et al., 2010), and no significant differences in responses regarding success of collaborative processes. Black respondents did provide a significantly ($p < .05$) more positive assessment of the collaboratives' capacity to address policy, systems, and environmental change than did non-Black respondents. On a scale of 1 = strongly agree to 7 = strongly disagree for agreement with the statement, "The Collaborative has the capacity to address policy, systems and environmental change approaches to improve Black birth outcomes," Black respondents had a mean of 2.9 (SD 1.1) and non-Black respondents a mean of 3.7 (SD 1.9); $p = .029$, overall mean 3.4 (SD1.7).

	BLACK* (N = 47)	NOT BLACK* (N = 85)	TOTAL* (N = 132)
How significant of an issue is African American Infant Mortality in [Your Community]			p = .018*
Not to Somewhat Significant	5 (10.6 %)	5 (5.9%)	10 (7.6%)
Very Significant	9 (19.1%)	37 (43.5%)	46 (34.8%)
Extremely Significant	33 (70.2%)	43 (50.6%)	76 (57.6%)
How equitably, or meaningfully, involved have African Americans been…in LIHF leadership overall…?			p = .289*
Not to Somewhat Involved	23 (56.1 %)	26 (40.6%)	49 (46.7%)
Very Involved	13 (31.7%)	26 (40.6%)	39 (37.1%)
Extremely Involved	5 (12.2%)	12 (18.8%)	17 (16.2%)
How equitably, or meaningfully, involved have African Americans been…in membership of the Collaborative in [Your Community]?			p = .095*
Not to Somewhat Involved	19 (48.7 %)	31 (47.0%)	50 (47.6%)
Very Involved	9 (23.1%)	26 (39.4%)	35 (33.3%)
Extremely Involved	11 (28.2%)	9 (13.6%)	76 (57.6%)
How equitably, or meaningfully, involved have African Americans been…in leadership or decision making of the Collaborative in [Your Community]?			p = .032*
Not to Somewhat Involved	23 (56.1 %)	22 (33.8%)	45 (42.5%)
Very Involved	6 (14.6%)	23 (35.4%)	29 (27.4%)
Extremely Involved	12 (29.3%)	20 (30.8%)	32 (30.2%)
How well has LIHF incorporated the assets and strengths of the African American community in [your community] into its strategies and/or actions?			p = .095*
Not at all to somewhat well	25 (59.5%)	55 (72.4%)	80 (67.8%)
Very well	12 (28.6%)	19 (25.0%)	31 (26.3%)
Extremely well	5 (11.9%)	2 (2.6%)	7 (5.9%)

Table 1 Responses to Key Survey Process Items[a] by Race.

*Totals for some items may not sum to given numbers due to non-response for those items. P-values calculated using chi-square test for independence.

[a]Selected items shown in table. No significant difference in perceptions on items regarding African American involvement in developing community action plans, involvement in community project grants, planning collaborative work, and strengths of LIHF as a leader in efforts to improve African American infant mortality.

QUALITATIVE SURVEY RESPONSES AND INTENSIVE INTERVIEWS

Theme 1: Power dynamics around race and racism were not sufficiently addressed

Black survey respondents had significantly lower assessments of how equitably they were involved in leadership than non-Black respondents. Several of the open-ended responses to the surveys discussed a lack of involvement in leadership of the Initiative or tokenism of those involved. Additionally, qualitative data revealed that Black academic partners and community members had lower assessments on racism, funding, community outreach and engagement, leadership cohesion, and the organizational structure of LIHF than white academics.

Theme 2: Power dynamics are complex

Black and non-Black interviewees offered insight into the complexity of the power dynamics within the initiative. The responses revealed that the community members were hoping that this Initiative would make steps towards reconciling the historical systemic racial trauma that Black residents experience throughout southeastern Wisconsin. Despite attempts by some of the leaders interviewed to address and seek to overcome the impact

HOW MUCH HAS LIHF AFFECTED THE FOLLOWING HEALTH ISSUES IN [YOUR COMMUNITY]	BLACK* (N = 47)	NOT BLACK* (N = 85)	TOTAL* (N = 132)
Reducing deaths of African American babies.			p = .154*
None	8 (20.0%)	10 (13.3%)	18 (15.7%)
A little	9 (22.5%)	28 (37.3%)	37 (32.2%)
Some	11 (27.5%)	25 (33.3%)	36 (31.3%)
Quite a bit/A great deal	12 (30.0%)	12 (16,0%)	24 (20.9%)
Improving the health of African American babies when and after they are born.			p = .732*
None	3 (7.7%)	6 (13.3%)	9 (8.0%)
A little	11 (28.2%)	24 (37.3%)	35 (31.0%)
Some	14 (35.9%)	30 (40.5%)	44 (38.9%)
Quite a bit/A great deal	11 (28.2%)	14 (18.9%)	25 (22.1%)
Improving the overall health of African American women			p = .469*
None	4 (10.3%)	8 (10.8%)	12 (10.6%)
A little	11 (28.2%)	23 (31.1%)	34 (30.1%)
Some	15 (38.5%)	30 (40.5%)	45 (39.8%)
Quite a bit/A great deal	13 (17.6%)	13 (17.6%)	22 (19.5%)
Reducing differences between African American and white babies health and their chance of dying.			p = .175*
None	9 (23.1%)	15 (20.0%)	24 (21.1%)
A little	10 (25.6%)	29 (38.7%)	39 (34.2%)
Some	11 (28.2%)	24 (32.0%)	35 (30.7%)
Quite a bit/A great deal	9 (23.1%)	7 (9.3%)	16 (14.0%)

Table 2 Responses to Survey Items[a] Regarding Outcomes by Race.

*Totals for some items may not sum to given numbers due to non-response for those items. P-values calculated using chi-square test for independence.

[a]Selected items. There were no significant differences in perceptions on items regarding effectiveness of each element of Lu's 12 point plan (Lu et al., 2010), nor on many items regarding functioning and success of the Collaboratives.

of differential power dynamics around race and racism, some community partners felt these attempts fell short of acknowledging and sufficiently addressing the issue. When asked how these challenges shape the initiative one responded explained:

> We can look forward. But what's going to be different about forward. Unless you know what happened in the past, you don't know what you're doing in the future. See, and that right there is how you can tell this initiative is not based on Black values and Black strengths. That whole concept of Sankofa[1] does not exist on this initiative. [Interviewee #14] Black Community Leader/Program Staff

When we asked white academic staff about these findings their response revealed the complex dynamic within the initiative. These interviewees suggested that the funding agency was not clear on the level of input that they were looking for from community partners.

> I think the Partnership Program might've thought they were being clear, but I think community organizations didn't necessarily understand what the boundaries were in terms of where they could influence the process and where their input wasn't really expected. So I think just being clear about what the parameters and how decisions were going to be made might've been helpful. [Interviewee #7] White Academic Staff

This critique also highlights how the funding agency dictates the dynamics throughout the Initiative. The Black interviewees stated that white collaborative members

failed to include them in the creation of the Initiative, and this negatively impacted how they experienced the project. One of our interviewees addressed this in an interview:

> The Lifecourse Initiative thought that by bringing these things to the table, people would utilize these things and we'll get better outcomes. And reality is you may have identified those issues, may even brought them to the table, but it wasn't with uniformity of bringing them to the table so that everybody was on one accord and in agreement. And so the disconnect between the services being provided and the services being delivered ended up being a disconnect. [Interviewee #21] Black Community Leader/ Program Staff

Theme 3: White-led institutions directing Black-focused initiatives is problematic

A related theme that emerged from the data is the complexity of white-led institutions directing initiatives that addressed health disparities in Black communities. The interviewees stated that although these universities may be providing the funding, they should not be planning on behalf of these communities. One of the program staff clearly stated in an interview: "The politics of white-led institutions and leaders planning on behalf of communities of color is a problem." [Interviewee #1] Black Program Staff

Black interviewees expressed that the level of control that the university had over the initiative was a major challenge. An academic partner addressed how offended Initiative members were because they did not have any control over the funds within the initiative and said this became a major point of contention within the project.

> ...it was always a conflict around who controlled the money. That was key, especially in Milwaukee. Milwaukee never, as long as I was there, as a group, never really came to accept the fact that they didn't have complete control of the resources and they resented that. It was always a conflict, and the feelings I think wore on the staff. I know it did; it wore on me. [Interviewee #13] White Academic Staff

DISCUSSION

Analyzing initial survey findings in a phased approach provided evaluators with a better understanding of survey responses, informed the design of interviews, and enriches the interpretation of all data.

POWER DYNAMICS AROUND RACE AND RACISM WERE NOT SUFFICIENTLY ADDRESSED

Despite efforts made by the funding agency, program office, and convening agency staff to be inclusive, qualitative data from the summative evaluation revealed that members of the Initiative who were not affiliated with the university felt that their experience was not as valued or appreciated. Unequal power dynamics pertaining to race and racism between community members and academic partners surfaced in survey and qualitative interviews. Many of the community-based interviewees stated that as LIHF began to gain momentum, they noticed that the Black community partners were not involved in the decision-making process. They stated that decisions would be made in meetings that did not include community members or partners. After the meetings, university representatives would ask community partners their opinions on decisions that have already been made. They stated that these types of actions added to the already fragile relationship between all parties involved.

WHITE-LED INSTITUTIONS DIRECTING BLACK-FOCUSED INITIATIVES IS PROBLEMATIC

Several of the non-Black academic partners also recognized this tension and expressed their limitations of operating within the university structure to create the systemic change that was needed. Although these non-Black academic partners believed that they were not intentionally withholding power from Black residents of southeastern Wisconsin, Black stakeholders did not believe them. While white academics stated that they were complying with the regulations of the funders, oversight committees, and the university's Board of Regents, they were perceived by the community stakeholders to be in control of the Initiative. Therefore, when decisions were made, community members were offended that they were not included in the conversations. The intentions of white academics and administrators could have been positive. Still, the history of anti-Black racism in southeastern Wisconsin and white-led institutions planning on behalf of Black communities contributed to how Black stakeholders experienced the power dynamics throughout the Initiative (Harris, 2012; Jones, 2009; Kendi, 2016; Race to Equity Project Team, 2013). In the face of complex power dynamics, academics must advocate for community presence in decision-making.

LIHF was envisioned as a community-academic partnership; however, the concept, funding, and control rested primarily with the university funding agency. It was the WPP's initiative; its vision, approach, funding process and leadership drove implementation of strategies for reducing Black infant mortality in southeastern Wisconsin. The funding mechanism resembled the

federal model of a "cooperative agreement" rather than an outright grant. However, this mechanism led to resistance from community leaders and may not have been well understood.

THE END OF LIHF

While the focus of this paper is on power dynamics, it is important to note that based on the Pregnancy Risk Assessment Monitoring System and vital statistics data, Black infant mortality disparities and new mother experience was disappointingly constant after 10 years of LIHF (Moberg et al, 2019). While there was no demonstrated change, there was near universal feedback that the Initiative should continue as disparities remained and the issue is critically important. Shortly after the summative evaluation of LIHF was complete, funding for the Initiative was ended. The funder has continued to invest in Black infant mortality through individual project grants aimed at improving maternal and infant outcomes, such as expanding doula services, mother- and father-specific collectives, and building capacity for community-based organizations to collaborate. However, the community collaborative structures described above were undone.

HOW DO WE SUPPORT NEW DYNAMICS?

Future efforts should have a more hierarchical approach with a centralized priority setting, narrower focus, transparent reporting, and accountability processes would yield a more integrated Initiative with a better chance of success between academic and community partners. Such a structure should continue to give voice to both the "grass tops" and "grass roots" (e.g., Christens and Inzeo, 2015) in the priority communities.

Based on feedback from our interviews, we suggest that university and community partners create steering committees. We believe that if initiatives are guided by diverse staff with content expertise, dissemination and implementation experience, and leadership respected in both the community and the university, it will show both university and community partners how to work together to address pressing issues. These steering committees should be composed of people from the impacted zip codes, offer free childcare and meals during meeting times, honorariums after terms, and be socioeconomically diverse.

Our review of the literature on collaboratives and coalitions found evidence that externally structured community collaboratives significantly influence population health outcomes primarily when they serve as vehicles to advocate for and assure the implementation of evidence-based policies and strategies (Brown et al., 2014). When Black stakeholders and organizations partner with academic institutions, these partnerships must develop organically. All parties can voice concerns, offer suggestions, and engage in healthy debates that enhance community health. All parties involved should have processes to check personal and organizational egos in these partnerships and be reminded that this work is not about the legacy or the reputation of these partners but the lives lost and impacted because of health disparities.

CONCLUSION

While infant mortality disparities are an important health outcome in their own right, they are also an important symptom of broader structural and social-economic drivers of health in Wisconsin. These drivers include historical factors leading to implicit bias and overt racism as well as structural racism and its economic and social consequences. Given the wide-ranging causes which cut across multiple levels of potential intervention, there is no easy solution to reducing Black infant mortality.

While the efforts made by this Initiative were appreciated and beneficial to the community and those who are severely impacted by infant mortality, Black interviewees demanded that an honest conversation be had about the underlying conditions that contribute to infant mortality and other related health disparities. In traditional community-academic projects, academics are situated at the forefront of most projects and are charged with creating plans, leading projects, and disseminating findings. Our evaluation shows that Black interview and survey respondents are interested in seeing a shift in the conventional approach of community-academic collaborations to a technique that centers the voices—and power—of those most impacted to advance health equity. Black community stakeholders were hired by the university to better connect university and community efforts. These stakeholders centered Blackness and were critical of white academics who disagreed that racism existed within the Initiative.

In order to have a healthy and productive partnership between academic and community partners, the impacted population must have a vested interest in the project; academic partners cannot dictate the terms of the collaboration, and all parties involved must benefit equally. If the community and academic partners are interested in making long-term, individual, familial, communal, and systemic transformations, they will have to restructure traditional community-academic collaborations and embrace forward-looking models of effective collaboration with Black communities.

NOTE

1 Sankofa is an African word derived from the Akan tribe in Ghana. Sankofa, translated means "it is not taboo to go back and retrieve what you have forgotten or lost." Sankofa can also be translated to mean learn from the past and continue to move forward (Temple, 2010).

COMPETING INTERESTS

The authors have no competing interests to declare.

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