

Declarative Statement to NIH

The purpose of the NIH designing grant funding for Community Engagement Alliance is to allow for academic institutions to work with community partners to execute public health interventions that impacts local communities. To be effective in this public health approach, academic institutions needed to demonstrate they work effectively to support and partner with community entities, grassroots organizations, and health organizations that serve the community. This was demonstrated through letters of support by community stakeholders in support of the funding proposals provided to the NIH by academic institutions.

The past 10 months of CEAL has demonstrated missed opportunities for academic institutions **to fully support community stakeholders who often execute the lion's share of the important work of reaching and intervening with distressed populations to bring about improved health outcomes and health responses in communities.** The same academic institutions that rely on community partners to translate, convey and disseminate academic knowledge and data, also make it extremely difficult for community organizations to gain access to funding and reimbursement within a reasonable time-frame, to engage the populations they serve daily and to do so in *real time*.

Universities create metrics that are inherently biased when allocating budget funding to community partners. They pre-determine the organization's size and operating budgets as indicators of that community organization's ability to be accountable to grant sub-funding, instead of valuing the partner's years of community work, deep roots in the community and track record of effective public health interventions in the intended communities. The outcome is that community organizations must wait months to receive sub-funding for work that must happen immediately, or hold tremendous amounts of costs or are unable to make payments to sustain work. The community partner's work is valued by universities as shown in their reporting, but universities leave community partners in the red for their work or grossly underfunded. The answer here is that these practices are rooted in upholding systemic barriers that privileges larger institutions over smaller, grassroots ones. We call this a subtle form of structural racism and discrimination.

The larger issue with NIH or federal funding aimed at community partnerships is that they often privilege larger academic institutions and primarily those that have limited reach into underserved communities, regardless of if those institutions are physically located in the same cities of the intended populations those grants aim to serve. Those institutions carry little to no trust with communities and the work of true engagement rests with community partners. Yet, universities or academic institutions, which the NIH privileges to execute such initiatives, then turn around and place extreme barriers for sub-funding on community partners who are the backbones of such initiatives.

Part of evaluating the effectiveness and sustainability of Community Engagement Alliances around public health interventions, mainly, at the moment, COVID-19, where disparities exist, mainly in Black and Brown communities, is for the NIH to ask, are community partners being adequately resourced to do the work that is needed to be done on the ground. The NIH needs to inquire in what ways are metrics used by funding mechanisms at academic institutions to restrict, withhold, tie-up, or exclude allocating funding to community partners and why? When those community partners are particularly led by people of color, to what extent are those community partners perceived as unable to manage sub-awards and to what extent does such calculations eliminate them from adequate funding they have been asking for to fully execute the work they can do in their communities and have proven they can do

in their communities. A Community Engagement Alliance cannot truly exist without the full and mutual support of community partners. As part of its larger evaluation of CEAL, I am calling on the NIH to survey those community partners who worked with these academic partners and to ask if they and the work they have done over the last 10 to 12 months has been substantially supported by their local CEALs and the ways in which the allocation of resources were skewed towards funding university overhead, compared to funding the work of community partners on the ground.

Academic institutions are vital for collecting scientific data that allows us to take the temperature of our communities. But the main drivers of true community intervention are the community partners who must then take this academic knowledge and do the important work of changing public health outcomes. They are the part of the equation that has their boots on the ground. Yet, they remain scrutinized through biased university funding practices, sidelined, underfunded and under-resourced in the effort to do so. Without a better evaluation of meaningful community engagement with partners, CEAL is not a sustainable initiative.

In solidarity,

Venus Ginés, MA, CHWI

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