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Dennis Nyachoti
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EVALUATING THE IMPACT OF THE IN-STORE PROGRAMMING AND OUTREACH COALITION (IPOC) ON INCREASING ACCESS TO HEALTHY FOOD AND HEALTHCARE SERVICES IN PASO DEL NORTE REGION: FIRST-PERSON ACCOUNT OF STAKEHOLDERS' PERSPECTIVE

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2020

EVALUATING THE IMPACT OF THE IN-STORE PROGRAMMING AND OUTREACH COALITION (IPOC) ON INCREASING ACCESS TO HEALTHY FOOD AND HEALTHCARE SERVICES IN PASO DEL NORTE REGION: FIRST-PERSON ACCOUNT OF STAKEHOLDERS' PERSPECTIVE

by

DENNIS OGETO NYACHOTI, BS

A THESIS

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The University of Texas at El Paso

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for the Degree of

MASTER OF PUBLIC HEALTH

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THE UNIVERSITY OF TEXAS AT EL PASO

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Abstract

Grocery stores can provide a conducive environment for interventions targeting healthy eating and access to health services, particularly in low-income communities. Nationally, several organizations have implemented grocery store interventions and have shown impact on perceptions of purchasing nutritious food, especially by raising awareness of fruits and vegetables. However, most of those programs have not been implemented in a coordinated manner despite being delivered in the same location. Collaboration of local health promotion organizations with grocery stores could increase consumers' access to and selection of healthy foods, as well as access to and use of services.

This evaluation of the In-Store Programming and Outreach Coalition (IPOC) uses first-person accounts from coalition members and a thematic analysis. To our knowledge this is the first qualitative study assessing the effect of such a coalition.

In this study, six coalition members from organizations delivering nutrition education, health screenings, and benefits enrollment (WIC and SNAP) provide their perspectives about the IPOC strengths, challenges, and recommendations. The strongest themes were the benefits of partnership, collaboration, and increased number of people reached, as well as a need for clear leadership and increased coordination.

In conclusion, we recommend the coalition identify a leader or leadership team that will act as a liaison for the partnering organizations. We also encourage future efforts to focus on designing quantifiable methods to assess the impact of the coalition on increasing access to and selection of healthy food, as well as access to benefits and health care.

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Chapter 1: Introduction

The United States Department of Agriculture (USDA) defines food insecurity as "having a limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways" (USDA, 2019). Households' food insecurity can be categorized into either "low food secure" or "very low food secure" (USDA, 2019). Low food secure households have enough to eat, but they may eat less of varied diet and in most cases, they utilize federal or community assistance programs (Coleman-Jensen et al., 2012). On the other hand, very low secure households modify their eating patterns or even reduce the amount of food they eat (Coleman-Jensen et al., 2012).

In the United States, about 12.5% of the United States general population were considered food insecure in 2017 (Healthy Paso Del Norte, 2019). In El Paso, Texas, nearly 10% of the population experienced food insecurity at some point during the year 2017 (Healthy Paso del Norte, 2019b). However, the prevalence of children (under 18 years of age) living in households that experienced food insecurity at some point during the year was higher in El Paso County (23%) compared to the US (17%) (Healthy Paso del Norte, 2019a). The Texas border region is predominantly Hispanic, exceeding 85% in each of the border counties (Sharkey, Dean & Johnson, 2011). Ethnic minorities, especially Latino, experience higher rates of food insecurity. In fact, over 25% of the Latino population lack adequate and consistent access to food (Coleman-Jensen et al., 2012). Other studies have also found that Latinos are four times more likely to lack access to healthy food choices than the general public (Hill, Moloney, Mize, Himelick, & Guest, 2011; Quandt, Arcury, Early, Tapia, & Davis, 2004).

Grocery stores may provide a conducive environment to increase availability of healthy food choices, particularly in low-income communities (Farmers market services, 2012; Seymour

et al., 2004). Philadelphia, Pennsylvania, is one of several locations that have implemented grocery store interventions from a policy, systems, and environmental changes perspective. Some of those programs have shown impact in changing participants' perception to purchasing nutritious food, especially through raising awareness of fruits and vegetables (Cummins, Flint & Matthews, 2014), as well as increasing ordering and stocking of healthy food choices (Davis et al., 2016). In addition, other regions have offered federally funded health and nutrition programs at grocery stores, with evaluations showing increased access to the programs, for example, the Philadelphian WIC program (Hiller et al., 2012).

In 2018, under the coordination of the Paso del Norte Institute for Health Living (now called the Center for Community Health Impact), the In-Store Programming and Outreach Coalition (IPOC) was formed to collaboratively work together to address food insecurity, nutrition education, and access to healthcare in El Paso County. The coalition members included representatives from the local public health department in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program; Centro San Vicente (CSV), a local Federally Qualified Health Center (FQHC) providing SNAP/Medicare/Medicaid enrollment outreach and assistance; Texas A&M University AgriLife Extension and the Colonias Program, delivering "Shop Heart Smart," a nutrition education program designed for food retail settings; and Food City and Food King supermarkets. They held regular meetings to plan, coordinate, and provide updates on the implementation progress. The coalition continued to accept other partners interested in improving access to healthy food and healthcare in Paso del Norte region, including the University of Texas School of Public Health in El Paso and the University of Texas at El Paso (UTEP), which both had teams funded through the City of El Paso to conduct health

screening services in underserved populations throughout the city. Figure 1 illustrates the logic model for IPOC, including inputs, activities, outputs, outcomes, and impacts.

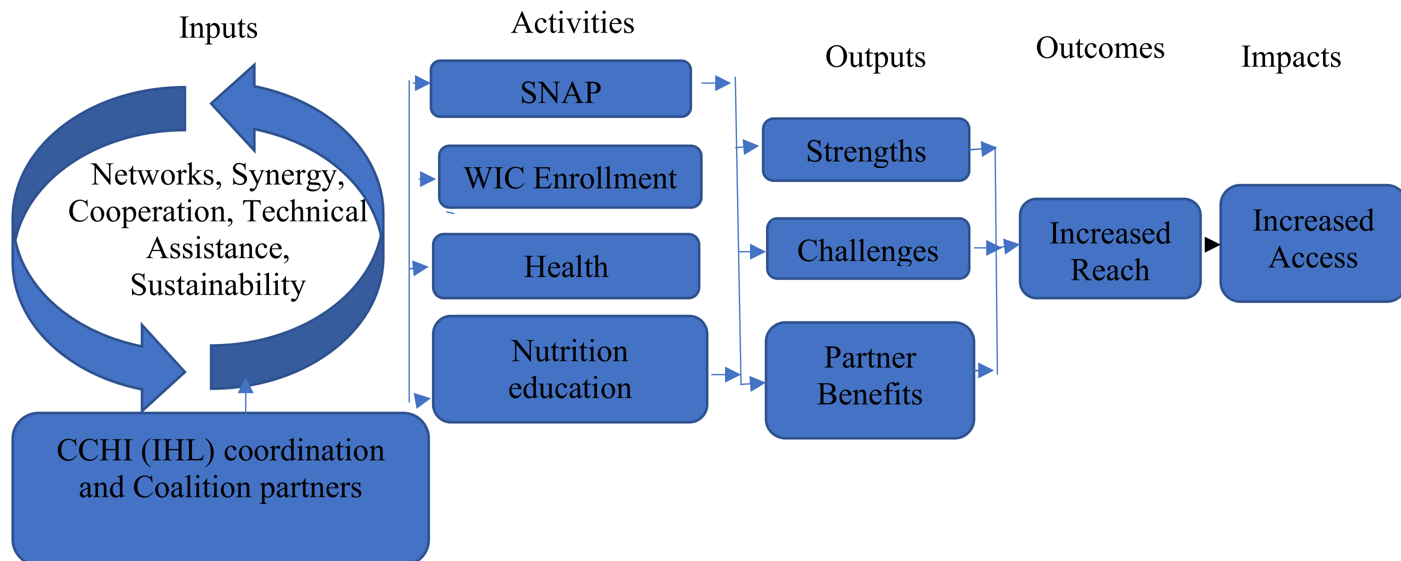

Figure 1: The In-Store Program and Outreach Coalition (IPOC) Logic Model

At the grocery store, the coalition partners coordinated delivery of programs and outreach to be simultaneous so they could cross-refer shoppers to the different programs in an effort to increase exposure of all shoppers to services from all coalition partners. Coalition partners communicated to ensure similar services were not overlapping at the same time and location (e.g. UTHealth and UTEP health screening teams alternated weeks at the same store). Each week, AgriLife or the Colonias Program would offer the Heart Smart nutrition education, El Paso Department of Public Health - WIC services offered WIC outreach and enrollment, Central San Vicente offered SNAP outreach and enrollment assistance, and UTEP or UTHealth offered health screenings. Store owners provided space to set up their tables.

The collaboration of local government agencies and non-governmental organizations with grocery stores could increase consumers' access to and selection of healthy foods, as well as

access to and use of healthcare services. Guided by a combination of theories: Community Coalition Action Theory (CCAT, Figure 2; Kegler, Rigler & Honeycutt, 2010; Butterfoss & Kegler, 2002), social ecological model (Figure 3; Bronfenbrenner, 1977), social cognitive theory (Bandura, 2014), and social marketing theory (Manikam & Russell-Bennett, 2016), the coalition aimed to change the status quo and improve community health. However, for the purpose of this study, we focus on identifying and demonstrating factors within a coalition through the CCAT for community change (Kegler, Rigler & Honeycutt, 2010) and the social ecological model (Bronfenbrenner, 1977).

CCAT consists of three stages formation, maintenance, and institutionalization. In the formation stage, a lead agency invites other partners who have similar goals and aspiration to form a partnership. Once a collaboration is formed, operations and activities as well as structures are initiated, a process referred to as maintenance stage, for a coalition to achieve its goals and objectives. Other coalition components such as synergy and pooling of resources also happen during this stage to sustain the coalition's activities. Outcomes of these activities inform community change (institutionalization), for example, community policies, practices, or behavior change adopted by the community. The coalition may return to the formation stages to expand or review its actions especially after reevaluating its implementation and outcomes (Butterfoss & Kegler, 2002).

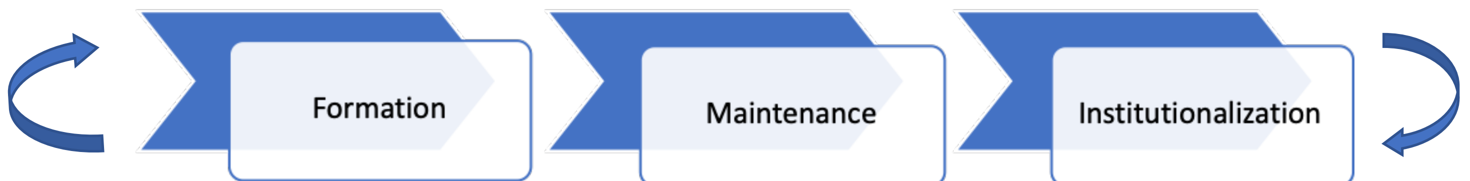

Figure 2: The Community Coalition Action Theory (CCAT)

Another theory or model applied by the IPOC is the Social Ecological Model (SEM). The SEM looks into human nature holistically. It considers all the social and physical environmental aspects that may influence a behavior at a community. The SEM has layers ranging from the immediate or individual level to the proximal e.g. the societal/community policies (Bronfenbrenner, 1977). In short, the IPOC utilizes the CCAT and SEM to inform policy, systems and environmental change through directly engaging individuals at the grocery stores, families, communities, organizations, and inform ideas on policy and practice change Lyn et al., 2013).

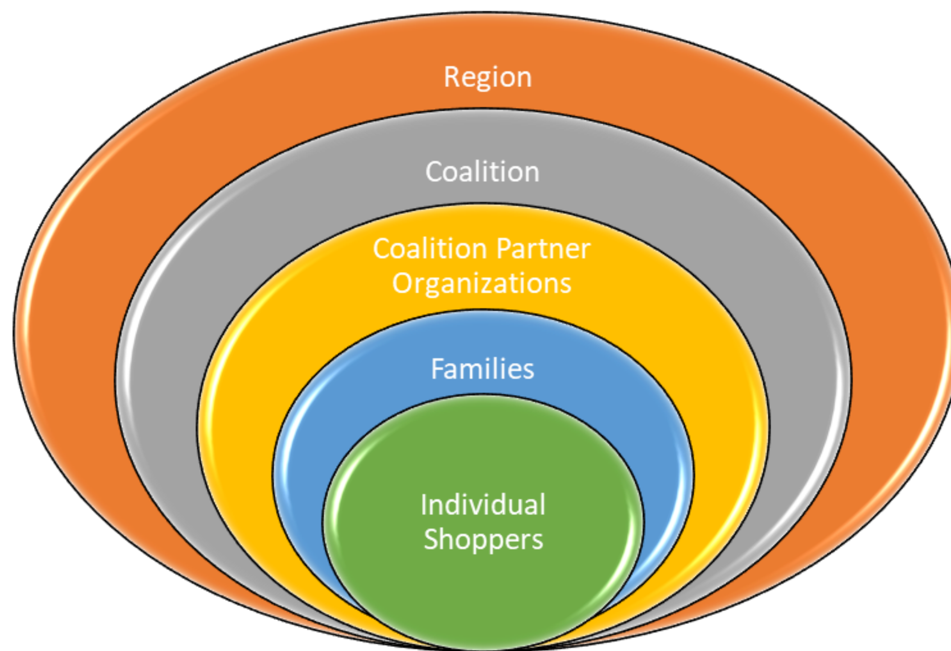

Figure 3: The Social Ecological Model (SEM)

Chapter 2: Background and Significance/Literature Review

Statement of the Problem and Significance

Nationally, numerous programs have been implemented in grocery stores to increase access to healthy food and change dietary behaviors among customers (Young et al, 2013; Holmes et al., 2012; Cawley et., 2015; Song et al, 2009; Adam & Jensen, 2016). However, typically those programs have not been implemented in a coordinated manner, despite the fact that most of these programs are implemented in the same location and they target the same health problems. When programs are implemented together, they can pool resources, talents, and strategies from multiple sectors which may effectively impact the health and wellbeing of populations (Martin et al., 2009).

Many coalition program evaluations have focused on the members' perception towards the success of their intervention (Powell & Peterson, 2014; Feinberg, Greenberg & Osgood, 2014) while others have looked into the collaborative efforts (Mattessich & Rausch, 2014), feasibility of public-private collaborations (Kempe et al., 2014), coalition empowerment and its effectiveness (Powell & Peterson, 2014), and communication strategies and coalition functioning constructs in the following six domains: leadership, participation benefits/costs, sustainability planning and community support (Brown, Feinberg, & Greenberg, 2012); organizational structures, and interpersonal relationships (McCoy et al., 2017).

To our knowledge this is the first qualitative study assessing the effect of a collaborative in-store coalition in the US-Mexico border and in the nation. In this study, we will present a narration of first-person accounts from stakeholders (coalition partners) who share their personal experiences in a grocery store coalition with regards to the coalition strengths, challenges faced

by the coalition, and benefits to their organization from participation in the coalition. Stakeholders were also asked for recommendations moving forward. A thematic analysis of those narratives would guide next steps and strategic planning for the coalition.

Review of Past Literature Relevant to the Problem

Low Socio-Economic Status (SES) and Food Insecurity

Food insecurity is associated with low socio-economic status (SES) (Rezazadeh et al., 2016). High unemployment rates, low-income, and low wages are consistently linked to food insecurity (Chritaldi & Cuy Castellanos, 2014). Even though with the introduction and utilization of food assistance programs, studies have shown participants running out of food and food assistance benefits before month end (Chritaldi & Cuy Castellanos, 2014). Furthermore, low-income households are less likely to cook and/or eat healthy food choices (Wolfson et al., 2019).

Costly food and poor transportation networks to the grocery store and other food sources are major challenges to accessing and acquiring healthy food (Chritaldi & Cuy Castellanos, 2014). For example, participants raised concerns of getting money to purchase healthy food in a needs assessment conducted in El Paso, TX and Juarez border (Manon et al., 2017). One participant with diabetes testified how she bargained between buying expensive healthy food and medicine (Manon et al., 2017).

Food Insecurity and Chronic Diseases

Food insecurity and chronic diseases such as diabetes, high blood pressure (Dixon et al, 2001; Weaver & Fasel, 2018), and high prevalence of obesity (Holben & Pheley, 2006) show a significant relationship between each other. High rates of chronic diseases are attributed to limited consumption of quality diet food (Maghsoudi & Azadbakht, 2012).

In one study, type 2 diabetes mellitus participants had increased risk of food insecurity compared to non-diabetic group (Hasan-Ghomi et al., 2015). People with obesity were 3.3 times more likely to be food insecure than normal individuals (Hasan-Ghomi et al., 2015).

However, some disparities such as gender and ethnicity may also play a role in the association between food insecurity and overweight or obesity. For example, moderate and severe food insecurity increased the chance of obesity among the Kurds as compared to the Azeris ethnic groups (Rezazadeh et al., 2016). Food insecure women were more likely to be overweight compared to food secure women across all ethnicities (Hernandez, Reesor & Murillo, 2017).

Access to Health Care

The US-Mexican region of Texas is mostly inhabited by low-income Mexican Americans (U.S. Census Bureau, 2014a). The majority of the population has low education and fewer job opportunities, along with high prevalence of communicable and chronic diseases (de Heer, Balcázar et al., 2013; Salinas et al, 2011; Spradling et al., 2013; Wright & Pritt, 2012). In addition to this, the border region is the most medically underserved and underinsured areas in the United States (Salinas et al, 2015). Particularly, those living along the US-Mexico border

have low rates of utilizing health screening and other public health prevention services (Balcazar et al., 2010). The few who seek health services do so at an advanced stage of disease (Balcazar et al., 2010).

In an El Paso, Texas study, having insurance was positively associated with chances of having regular blood pressure and blood glucose checks, cholesterol screening, and any preventive screening services (Salina, 2015). In addition, Hispanics living in the US-Mexico border region had significantly lower odds of having health insurance and utilizing healthcare services (Shen, Gai & Feng, 2016). Besides low health insurance coverage, Hispanic populations face other barriers to accessing health services such as, cognitive, structural, and financial barriers (Rosenberg, 2017; Palomino et al., 2017), as well as undocumented status (Monga, Keller & Venters, 2014).

Access to Federal Funded Nutrition Programs

The USDA introduced the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, to improve health and wellbeing of the American population facing difficulties to put food on their tables (Borjas, 2004; C-SNAP, 2007). Households with a gross income of 130% of the federal poverty guideline or having an elderly or disabled member are eligible for the SNAP program (Mancino & Guthrie, 2014).

Undocumented immigrants are ineligible to participate in SNAP, but their children can participate in the program if they meet the income level eligibility criteria (Choi, Fram & Frongillo, 2017). Dissimilar to SNAP, WIC program for pregnant, postpartum, or breastfeeding women and children up to the age of five does not require citizenship or any authorization to participate (USDA, 2016).

Despite evidence that food stamp participation is associated with reduced food insecurity (Bartlett, 2003), food insecurity still remains a major burden in many low-income households in the United States (Hook & Balistreri, 2006; Lombe, Yu, & Nebbitt, 2009; Yu, Lombe, & Nebbitt, 2010). The reason behind it could be due to lack of knowledge, misconceptions, immigration status, and lack of access to the services. For instance, over forty-two percent thought they did not need food stamps, while 34·9 % did not think they were eligible or they did not know how to apply for the food stamps (Kaiser, 2008). Additionally, others expressed concerns that food stamp application could make them ineligible for citizenship applications while others felt that they might be discriminated against or stigmatized by community members for using food stamp services (Kaiser, 2008). Another study documented that Latino immigrant families feared facing repercussions if they accessed government services, such as future denial to receive college aid, having their undocumented children taken away by the government, being required to pay back the assistance, and possibly being deported (Pelto et al., 2019).

In-Store Interventions

Retail grocery stores have been given attention while addressing food environment systems change (Glanz & Yaroch, 2004; Story et al., 2008; Cheadle et al., 1991). Most households in the high-income countries, including the United States, have reported that they get their food from retail food stores and supermarkets, and a majority buy food about twice per week (Food Marketing Institute, 2014). Grocery stores and supermarkets can provide access to healthy food, especially fruits and vegetables (fresh produce), whole grains, low fat milk among others (Glanz, Bader & Lyer, 2012).

For instance, interventions in food retail stores increased purchase and availability of healthful food among two-low-income neighborhoods in Philadelphia through incorporation of

WIC in the stores (Hillier et al., 2012). However, further studies may be required to assess the relationship between the purchase of healthy food and the actual consumption (Hillier et al., 2012).

Issuance of incentives such as SNAP to customers may increase purchase of healthy food choices. For instance, program users reported consuming increased amount of fruits and vegetables compared to non-users in Philadelphia, Pennsylvania (Young et al., 2011). Farmer's markets that initiated a SNAP program increased SNAP sales 5-fold compared to year before the program was initiated (Young et al., 2011).

Another study in low-income neighborhoods of Philadelphia, PA and Wilmington, DE showed that an intervention using signage and displaying healthy food items in stores significantly increased the purchase of healthier food choices as compared to the control supermarkets without the intervention (Foster et al., 2014).

Community Health Coalitions

A coalition is "a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal" (Butterfoss & Kegler, 2002). In some cases, coalitions use a top-down approach, where professionals take an upper hand in leading the actions while mobilizing communities to act to promote their health (Francisco, Paine & Fawcett, 1993).

A coalition is formed when different sectors and organizations are merged to achieve a collective purpose, goal or agenda (Gray, 1991; Feighery & Rogers 1990; Himmelman, 2001). Coalitions are built on the assumption that minimal success could be achieved when the interventions are implemented separately as compared to a coalition/partnership approach (Butterfoss, Goodman & Wandersman, 1993).

For strengthening partnership and collaboration in coalitions, the following components should be present:

Synergistic Cooperation

Synergistic cooperation is "exchanging information, altering activities, and sharing resources for mutual benefit and having a common purpose" (Hilmmelman, 2001). In addition, the Oxford English dictionary defines synergy as "the interaction or cooperation of two or more organizations, substances, or other agents to produce a combined effect greater than the sum of their separate effects."

Synergistic cooperation could be achieved when resources are pooled together, members engage each other, and the coalition has the ability to plan for its activities effectively (Butterfoss & Kegler, 2009). Synergy occurs when a "team deviates from the norm" (Rahwan, Michalak & Wooldridge, 2014). Other scholars posit that having trust amongst partners is an indicator of synergy and a building block to coalition sustainability (Jagosh et al., 2015).

Sustainability

Prior planning for sustainability predicts coalition survival, especially in regard to funding opportunities (Feinberg, Bontempo & Greenberg, 2008). In one study in Pennsylvania, ninety percent of coalitions continued for 3 years after the initial funding period (Feinberg, Bontempo & Greenberg, 2008). This unprecedented sustainability was attributed to proper planning for sustainability during the coalitions' formative stages (Feinberg, Bontempo & Greenberg, 2008). Moreover, many of these coalitions attracted funding from other funding sources after the primary funding season (Feinberg, Bontempo & Greenberg, 2008).

Capacity Building and Technical Assistance

One of the other major functions of a coalition is to increase the capability of its members and the community at large to promote their health. Capacity building creates solutions at individual level, organizational and societal level (Chaskin, 2001). Some scholars have basically defined capacity building as the ability to perform one's objectives (Goodman et al., 1998). Capacity building is an ongoing process of improving a person's or group's ability to perform daily functions or work (Brown, Lafond, & Macintyre, 2001). In a collaborative perspective, capacity-building promotes a strong inter-organizational network and participation (Labonte et al., 2002). Technical assistance also helps coalition's staff and members to be more effective and efficient in the delivery of their services (Butterfoss, 2004).

Several studies have shown positive impact with coalition functioning and implementation through technical assistance (Brown, Feinberg, & Greenberg, 2010; Riggs, Nakawatase, & Pentz, 200). For example, in a recent study, increased coalition's capacity was strongly correlated with changes in community readiness to fight underage drinking practices through an interactive model of training and technical assistance (Anderson-Carpenter et al., 2017).

Internal coalition capacity significantly increased after intervention coalitions were involved in-person training and technical assistance calls from university staff (Watson-Thompson et al., 2014). Also, in another study, leaders narrated how they had significantly benefited from the coalition's sharing education and training opportunities, which enhanced communication with the public, staff and resource sharing (Walsh et al., 2015). Technical assistance improved

implementation strategies especially with documenting progress, measuring outcomes and sourcing funding opportunities for sustainability (Keene Woods et al., 2014).

Networking

Networking is the "exchanging of information for mutual benefit" (Himmelman, 2001). It is a very useful strategy for organizations that are in the initial stages of working relationships. Typically, coalitions start meetings with each member introducing him/herself to assist in networking (Wolff, 2010, p. 44). Although this is a great approach, Wolff (2010), argues that is not sufficient for an effective collaboration, but exchanging information and modifying activities for mutual benefit is (Wolff, 2010, p.45).

Evaluating Coalitions

Measuring success of coalition's impact and its internal processes is paramount. The data collected could offer regular checks and provide regular feedback to coalition members (Francisco, Paine & Fawcett, 1993) and other stakeholders such as grant makers (Francisco, Paine & Fawcett, 1993; Cardazone et al., 2014). Past studies have focused on the internal operations and functioning of a coalition as a predictor of a successful coalition (Riggs, Nakawatase & Pentz, 2008). Also, there are many other studies that have assessed the effectiveness of coalitions to deliver health services, but questions on their validity and reliability have been raised, especially with finding an appropriate and unified evaluation methodology (Granner & Sharpe, 2004). There is, however, need for stakeholders to reflect and share their thoughts about coalitions' theory of change. Therefore, this will be a unique perspective for

stakeholders to be heard regarding their experiences with coalitions and suggest recommendations.

Chapter 3: Research Objective and Research Questions

The IPOC was formed with an overarching goal to increase access to and selection of healthy food through simultaneous implementation of nutrition education, health screenings, and SNAP and WIC outreach and enrollment in the grocery stores. The main objective of this study was to gather information on the effectiveness of the coalition through input from coalition partners. In particular, we sought to understand partner's perceptions of coalition strengths and challenges, as well as benefits to their organization by participating in the coalition.

Overarching Research Question

- Is the IPOC effective at increasing access to and selection of healthy food?

Specific Research Questions

1. What are the strengths of the IPOC in relation to achieving its goal?
2. What are the challenges or shortcomings with the IPOC?
3. What are the benefits to your organization by participating in IPOC?
4. What are the recommendations for the IPOC?

Chapter 4: Methods and Materials

Overview of the Study

The objective of this study was to learn from stakeholders' perspective about formation of IPOC and implementation of the coordinated programming and outreach (SNAP, WIC, Heart Smarts, and health screenings). The coalition served customers shopping at local grocery stores located in El Paso, TX.

IRB Approval

An Institutional Review Board (IRB) approval was obtained from The University of Texas at Houston School of Public Health (primary institution) and The University of Texas at El Paso. All participants signed an informed consent form prior to providing their perspectives and/or undergoing an interview.

Study Participants

The study participants were coalition members who participate in grocery store interventions (WIC, SNAP, Heart Smart, and health screenings) and store owners or their designee.

To ensure each organization was represented, more than one narrative was invited from partnering organizations that had more than one member engaged in the coalition. In most cases, only a single usable narrative was received. The most common reason why a narrative was not used was that the person responded to prompts in the context of their program only, rather than the coalition. In the case of one grocery store manager, only one coalition partner had delivered a

program at the store (i.e. the coordinated efforts of the coalition had not offered at that store). A total of 10 coalition members completed the evaluation study, but only six narratives met the described purpose of the study.

Table 1: IPOC Members and the Organizations

Program/Service	*Organization*	*Coalition Member*	*Narrative*
Heart Smarts	Texas A&M Colonias	Coordinator	Included
		Community Health Worker	Responded related to organization only
Heart Smarts	Texas A&M AgriLife	Coordinator	Incomplete answers; no follow-up
		Community Health Worker	Responded related to organization only
WIC	City of El Paos, WIC	Public Health Specialist	Included
SNAP Enrollment	Centro San Vicente	Outreach and Enrollment Manager	Included
Health Screenings	UTHealth	Research Coordinator	Included
Health Screenings	UTEP	Research Assistant	Included
Grocery Store	Food City	Manager	Included
Grocery Store	San Eli Supermarket	Manager	Experience limited to a single program

Study Design

This was a qualitative study design using first-person accounts of stakeholders. A first-person account or narrative is a specific publication type in the American Journal of Community Psychology. The journal provides this description of such narratives:

> Another article type is a First-Person Account, which provides a forum for one or more stakeholders to share their "lived experience" with research, practice, or policy. A First-Person Account usually consists of an integrative Introduction and Discussion that bookends narratives from collaborating authors, thus providing a "360" window into the diverse and situated perspectives of various stakeholders engaged in community research and action (American Journal of Community Psychology, 2016).

This study design provided a unique opportunity to the stakeholders to reflect on the coalition and how it has impacted their organizational goals, including but not limited to identifying the coalition's strengths and challenges (Symthe-Leistico et al., 2012; Brown et al., 2013). Narratives could shape and inform policy formulation, as well as provide opportunities to connect with broader social groups and populations represented by narrators (Niederdeppe et al., 2008). Also, some information or experiences from stakeholders could not be quantified, therefore, a first-person account approach was chosen.

Data Collection

The coalition members were emailed an invitation to participate in this evaluation. The email included a copy of the consent form. The participants were asked to reflect on their experiences and share their insights and views in a personal written response (prompts were provided to them). The investigator followed-up by phone and email to clarify any responses

that were unclear. In one case, the participant preferred to do a phone interview rather than write the responses personally. All responses were compiled into a comprehensive narrative for each organization (see below).

Measures

Coalition members who deliver in-store interventions were provided with the following prompts:

- Why did you decide to participate in the in-store coalition?
- What has been the biggest advantage to participating in this coalition?
- How has the coalition impacted your program? (Probe: goals, knowledge, capacity, technical assistance, etc.)
- What is different when you implement your program separately from the coalition compared to in coordination with the coalition?
- Narrate or give your personal experiences with clients/customers and how they received the in-store coalition program?
- How effective has the coalition been? Include some examples where possible
- Do you consider the in-store coalition a success? Why and/or why not?
- What are some of the challenges you have experienced in the in-store coalition?
- What are some of the barriers you might have witnessed with shoppers e.g. stigma, discrimination, cultural issues etc.?
- What could have been done better?
- Do you have any recommendations for this coalition?
- What else should we know about the impact of this coalition?

Coalition members who are store owners:

- How has the in-store program delivery by coalition members impacted your customers?

- How has the in-store program delivery by coalition members impacted your business?
- What are some of the challenges you have experienced in the in-store coalition?
- What could have been done better?
- Do you have any recommendations for this coalition?
- What else should we know about the impact of this coalition?

Process Evaluation

The investigators created a spreadsheet with columns of responses for each respondent. Two investigators independently read the responses to derive text "meaning units" (*decontextualization*) (Bengtsson, 2016). Then the investigators identified how each "meaning unit" answers the research questions and purpose of the study. Those participants whose responses did not meet the criteria or purpose of the study were excluded and reserved for future analysis. The investigators compiled the written responses for each participant and created a first-person narrative/account. The narratives were shared with the respondents to confirm accuracy and correct understanding and make any edits they deemed appropriate. The investigators then matched each meaning unit to the respective research question (re*contextualization*) (Bengtsson, 2016), and compiled themes and categories (*categorization*). Finally, the investigators reached a consensus on the most suitable themes for the discussion (Bengtsson, 2016).

Chapter 6: Results

This evaluation gave stakeholders of the IPOC a unique opportunity to reflect on their experiences and share their thoughts about the coalition. Below are first-person accounts as presented and co-authored by each member involved in the delivery of the in-store programming and outreach and the store owners/managers. The evaluation focused on the coalition's strengths, challenges, and recommendations as reported by the coalition members.

First-Person Account #1: Coordinator, Heart Smarts Colonias Program

We joined the coalition and its partners because of the opportunities to enhance the nutrition education services we already offer in the grocery stores. We wanted to create a healthier community where we could provide free services to improve the health or well-being of people. The objective of the coalition is to offer complementary health related services for the consumer. Having other coalition members to provide input and feedback on possible improvements or problem solving has also been an advantage of coalition partnership. Participation in this coalition has increased our understanding of integral operations of grocery stores as well as the Healthy Food Financing Initiative. I was able to directly observe the benefits of coordination of coalition members. For example, I witnessed several customers take the opportunity to consult with the WIC representative about eligibility and benefit questions, for which they received immediate guidance.

The coalition has been effective in networking and coordinating many diverse organizations to deliver programs and outreach simultaneously. However, even greater coordination is needed, especially when changes within organizations, such as personnel, can deter progress somewhat. In addition, it is often challenging to coordinate with store

managers. This could be due time pressures on store managers and, in the case of some stores, a lack of understanding of the programming delivered and the value it can bring to the stores and their customers.

Some practical suggestions for increasing coordination and impact include inclusion of the recipe of the week in the store flier, better signage within the store directing shoppers to the coalition activities, and feedback to store managers regarding the numbers and types of customers engaged so they can better see the impact of the programming. In addition, it would be useful to have a brief document outlining the purpose of the coalition that could be shared when approaching new stores to help reduce anxiety or mistrust in adopting this kind of programming in their stores. There are many stores that are interested in hosting the coalition partners, so it is important that we find ways to expand our capacity.

First-Person Account #2: Manager, Food City Supermarkets

The program delivery by the in-store coalition members in our stores has a positive impact on our customers. Some of the activities conducted such as offering shoppers demonstrations of recipes that they can make at home has been beneficial. It has also impacted our stores positively because the recipes feature ingredients that are in our weekly advertisement special. In most cases, we see an increase in sales of items used in the recipe demonstrations, which is a good thing for our business too. One challenge we have faced is that some recipes do not resonate with the older customers. If nutrition education coalition partners could identify recipes that better meet the needs of this specific clientele, that would useful.

One thing that could be improved upon is to have better coordination between the demonstration recipe of the week and the displays we set up in the store to ensure ingredients for the recipe are prominently displayed so customers know how to find it. We would also be willing to offer pricing incentives that align with the ingredients that are featured in that week's recipe.

Having seen how the in-store coalition is impacting our customers, who are primarily low-income, we hope the coalition will continue working in our grocery stores to reach low-income members of our community.

First-Person Account #3: Public Health Specialist, WIC Program, City of El Paso Public Health Department

I decided to participate in the in-store coalition to increase awareness of our program out in the community. One of the biggest advantages of being part of this has been creating a partnership with other organizations. Also, since joining the coalition we have seen an increase of participation in our program in the grocery stores. The coalition has positively impacted our program by increasing awareness of our program. We have also been able to build stronger partnerships with the community and collaborating agencies in this coalition.

There is a difference, however, when we implement our program separately from the coordinated effort of the coalition. The services we offer are a little more limited, so the customers benefit from the coordinated delivery of programming and outreach offered by other coalition members. The customers were extremely positive and grateful for the information and were happy to see us out at the grocery stores. I consider the in-store

coalition a success because we were able to reach different populations at the grocery store than through our other outreach channels.

We primarily faced two challenges with our outreach efforts as part of this coalition. First, the time when we were out at the stores sometimes did not align with when our target population was shopping. Secondly, some shoppers were hesitant to talk to us because of what seemed to be a point of pride – they did not want to be associated with an assistance program. This is not an uncommon challenge in our outreach efforts, but because the coalition activities take place in such a public location, this challenge may be slightly higher in this setting. However, given that we can reach more and different people, this is a worthwhile trade-off, making our partnership in the coalition well worth our time and effort.

First-Person Account #4: Research Coordinator, UT-Health Science Center at Houston | El Paso Campus

We joined the In-store coalition to give us an opportunity to connect our program, Healthy Fit, to additional community resources that complement or resonate with our program. We were also drawn to the coalition to offer our program in a grocery store setting while collaborating with other health promotion programs.

The coalition has brought together programs working on similar goals and made it possible for them to implement their work as part of a team. The biggest advantage in this teamwork has been the opportunity to offer health screenings at a grocery store. We have also gained knowledge about other health promotion programs and services available in the community, particularly the criteria some of them consider for clients to qualify in certain services such as WIC and SNAP. The collaboration with Heart Smarts

at Food City benefited our program's implementation because as we reviewed the participants' health measures with them, we could refer them to the Heart Smarts program, or if they had already seen the nutrition lesson, we could draw from some of the information that they had just received to emphasize the importance of healthy food choices for improving health measures overtime.

In our experience at the grocery store, shoppers would enter the store and make their way to the produce section where they would be greeted by the Hearts Smarts team. After speaking with them, Heart Smarts staff would direct people towards our table. Our Community Health Workers (CHWs) would then offer the health screenings to the participants. If people were not shopping in a rush, they would at least stop by our table to learn about our program. Often, participants were a little shaken to learn about their unhealthy measures (high blood pressures, high BMI, high fat percentage etc.) and how these measures put them at risk of developing chronic diseases, but I think the grocery store setting really helped motivate them to start making healthy lifestyle changes. We noted that many participants who received the health screenings were motivated to apply what they had learned from the Heart Smarts team on healthy eating. For instance, after receiving their screening results, multiple participants looked at the items in their shopping cart and reassessed what they should be purchasing.

Challenges we noticed included conflicting schedules that meant we did not get to offer the program in collaboration with some of the other organizations/programs that are part of the coalition. Also, we noticed after a few weeks that we were seeing the same families and individuals at the store. Since we cannot have duplicated participants within our program, it became a challenge. Another barrier was the lack of privacy to conduct

the health screenings. Some participants felt uncomfortable because there was no privacy to obtain their health measures.

Some ways to improve the coalition efforts include involving the grocery store managers in the coalition's plans in order to better promote the programs that were being offered. Also, I think some kind of guide that describes each coalition member's programs and how they are tied to the coalition would be very helpful. Finally, it would be helpful if the coalition would identify funding opportunities to support its activities.

First-Person Account #5: Research Assistant, The University of Texas at El Paso

The coalition provided a good opportunity to partner with other organizations and reach more venues to offer the services of our project. The biggest advantage to joining the coalition has been that it is easier to establish a relationship with the store managers and secure a spot to offer our services on-site. Thanks to the coalition we were able to set up a booth inside the stores and increase the number of participants we served. We also learned more about the services being offered by other partners at the site.

Compared to when we offer our services in other venues (e.g. health fairs), when we coordinate with the coalition partners in grocery stores, we encourage all of our participants to visit the tables from our partners. In a similar way, people that approach our partners first are encouraged to participate with us as well.

We have experienced a positive reception from grocery store customers. They are grateful that we bring health screenings to them. Several of our participants do not have health insurance and haven't visited a doctor within the last 12 months. We provide them with their health screening results and provide them a referral when a test result

indicates they are at increased risk for a health problem. They seem interested in learning more about recipes for healthier diets using low-cost foods.

The coordinated efforts of the coalition partners have been very effective at reaching out to vulnerable populations (e.g. uninsured and low-income). Many of the people shopping at the locations targeted by the coalition partners are not aware of their health status. When we provide them with their health screening results, they often want to take action by approaching the other coalition partners to receive more information.

While the coalition has been successful at reaching a high-need population that will benefit the most from the services each of our partners offer, there is still room for improvement. We need better coordination, regular communication among partners, and clear agreement on collective goals and shared outcome measures. One example where coordination broke down was when there was a delay hearing back from a store manager to get permission for delivery of coalition programs and outreach. Some partners moved on to other venues before coordination could be completed. In addition, there were days when some coalition members would not arrive at the venue as planned. It seems we need one centralized coordinating entity or partner who can lead communication with store managers and among coalition partners.

Language and cultural appropriateness could have been a barrier, but fortunately, many of our partners and participants are from a Latino/Hispanic background, and that is an asset. In the grocery store, I have noticed that participants are more open when they are approached in their first language. For instance, when people approach our booth, we greet them in English and Spanish and we continue the conversation in the language they

are most comfortable with. Also, I like that most of the recipes offered by our partners (Heart Smarts) are culturally appropriate for our region..

First-Person Account #6: Outreach and Enrollment Manager, Centro San Vicente Health Center

Before this coalition formed, our team was providing benefits enrollment support in grocery stores. When the coalition first came together, we thought it was a great opportunity to partner with other organizations that shared similar goals and served the local community. One of the biggest advantages of joining the in-store coalition is that we have created a great partnership with these organizations and expanded our outreach to the community. Also, this partnership has helped us learn from the other programs in the coalition and share various ideas on how to improve our program.

Compared to when we were implementing our program separately, the coalition has helped us reach a larger population and increase engagement. For instance, in the days my staff were in the stores with other coalition partners, they reported shoppers were excited about the on-site delivery of the programs and engaged with different services offered by coalition members.

The coalition has been extremely effective at increasing the number of people reached. For example, outreach efforts focused on WIC and SNAP, which are part of this coalition, benefit the low-income population in the region. The coalition has provided a new way to reach this population effectively. Other programs in the coalition, such as Heart Smarts, focus on educating shoppers about how to select and prepare healthy foods which help our community members use their WIC or SNAP benefits to change their eating habits for better health outcomes.

Chapter 7: Discussion

The first-person accounts narrated how and why they joined the IPOC. Most narratives noted they mainly joined the coalition to partner with community agencies who shared common goals and vision. For example, account # 4 wrote, “We joined the In-store coalition to give us an opportunity to connect our program, Healthy Fit, to additional community resources that complement or resonate with our program,” and added “The coalition has brought together programs working on similar goals and made it possible for them to implement their work as part of a team.” This concurs with the CCAT formation phase where partners who have similar goals and aspiration collaborate to form a partnership (Butterfoss & Kegler, 2002).

All narratives reported various activities and operations they undertook in the grocery stores, including health screenings, WIC enrollment, SNAP enrollment, and nutrition education. The partners also narrated how they cross-referred shoppers to each other as an indication of coordinated efforts within the coalition. These actions resonate with the CCAT maintenance phase which focuses on the operations and activities of coalitions (Butterfoss & Kegler, 2002).

Several partners also described how the coalition had increased access to a broader population. For instance, account # 6 noted, “Compared to when we were implementing our program separately, the coalition has helped us reach a larger population and increase engagement.” The main outcome of the IPOC was to increase people reached with coalition’s services (Figure 1), which aligns with the institutionalization phase (Butterfoss & Kegler, 2002).

The narratives provide perspectives on the strengths, challenges, and recommendations of the IPOC. One of its most significant strengths was the ability to increase collaboration with other partners and increase the number of people reached by each program in the IPOC (account 1,3, and 4). Cross-referral of shoppers from one program to the other potentially exposed the

shoppers to services offered by the partners and reinforced information on healthy living (account 4). The collaboration managed to pool resources existing within the community, for example, by meeting at the grocery stores and taking services to where the population can be reached.

Besides the benefits, the first-person accounts discuss several challenges faced by the IPOC. We present them as coalition specific and location specific or program specific. For the IPOC specifically, lack of proper coordination and leadership were identified as the major challenges experienced with the coalition. The first-person accounts recommended some strategies such as having a leading entity to spearhead the coalition and help with coordinating activities. For location specific challenges, partners reported lacking exposure to new people after several weeks of program outreach at the same time and location. Recommendations included expanding services to other stores. We discuss each of these strengths, challenges, and recommendations below. We hope community partners interested in taking on similar coalition or collaborative initiatives can learn from these narratives

Coalition Specific Strengths

1. **Synergistic Cooperation (Pooling Community Resources and Complimentary Activities)**

One of the most significant roles of any coalition is sharing resources (Butterfoss & Kegler, 2009). When resources are pooled together, members engage each other, and the coalition has the ability to implement activities effectively and efficiently (Butterfoss & Kegler, 2009). The IPOC is a multi-organization system working together to increase access to healthy food choices and health care. As noted by several coalition partners, the pooling of resources and

access to additional resources were some of the main reasons that motivated members to participate in the coalition. For example, account #4 noted the importance of the "opportunity to connect our program, Healthy Fit, to additional community resources that complement or resonate with our program." In the IPOC context, provision of a space within the grocery store is an example of shared resources.

In addition, coalition partners shared how the coalition contributed to strengthening their programs. For instance, account # 4 noted, "The collaboration with Heart Smarts at Food City benefited our program's implementation because as we reviewed the participants' health measures with them, we could refer them to the Heart Smarts program, or if they had already seen the nutrition lesson, we could draw from some of the information that they had just received to emphasize the importance of healthy food choices for improving health measures overtime." Similarly, account #1 states, "The objective of the coalition is to offer complementary health related services for the consumer." As observed from these narratives, complimenting what already existed could have contributed to strengthening service delivery and reinforcing prior service with limited and/or available resources.

2. Passion for the Community

In many public health programs, self-motivation and passion for community change are drivers to success (Luo et al., 2014; O'Donnell, 2009). Several coalition partners expressed how passion for changing the community's health contributed to them deciding to join the coalition. For example, account #1 notes, "We wanted to create a healthier community where we could provide free services to improve the health or well-being of people." Also account #5 wrote, "The coordinated efforts of the coalition partners have been very effective at reaching out to vulnerable populations (e.g. uninsured and low-income)."

3. **Networking, Coordination, and Collaboration**

One of the key foundations of this coalition and many other coalitions, is to establish a partnership and collaboration toward a shared vision or common goal. Coalition formation assumes that less can be achieved when programs are implemented separately compared to as a coalition (Butterfoss, Goodman & Wandersman, 1993). Himmelman (Himmelman, 2001) notes that coordination includes networking, the sharing of information about each other's organizations for mutual benefit, as well as modifying activities for mutual benefit, often leading to "more user-friendly access to programs, services, and systems." The majority of narratives noted that the coalition helped them establish partnerships with each other. For example, account #3 stated, "We have also been able to build stronger partnerships with the community and collaborating agencies in this coalition." Account #6 noted, "One of the biggest advantages of joining the in-store coalition is that we have created a great partnership with these organizations and expanded our outreach to the community." These two examples show how the partners feel the coalition has been able to expand their services to the community and gained by the mutual benefits such as the shared resources noted above.

4. **Capacity Building and Technical Assistance (Empowerment, new ideas, and knowledge sharing)**

Most narratives reported the coalition had created an avenue for self-empowerment and sharing new ideas and knowledge. For instance, account #1 stated, "Having other coalition members to provide input and feedback on possible improvements or problem solving has also been an advantage of coalition partnership." The narrator adds that, "Participation in this coalition has increased our understanding of integral operations of grocery stores as well as the

Healthy Food Financing Initiative." Also, account #6 noted, "This partnership has helped us learn from the other programs in the coalition and share various ideas on how to improve our program." Various studies have shown internal coalition empowerment and technical assistance have been effective in strengthening coalition functioning and implementation (Brown, Feinberg, & Greenberg, 2010; Riggs, Nakawatase, & Pentz, 2000). Also, internal coalition capacity enhances communication with the public, staff and resource sharing (Walsh et al., 2015). According to the narratives, the coalition partners have built their capacity with other partnering agencies and shared ideas on how to expand and strengthen their service delivery.

5. **Coordination - reinforcement for behavior change, referral of shoppers to different programs within the grocery store**

The genesis of the IPOC was to coordinate delivery of services among coalition members' programs. Specifically, it was theorized that when the programs are implemented at the same place and time, coalition partners would cross-refer shoppers and by so doing, increase exposure of shoppers to all services offered the IPOC. Several coalition members reported that shoppers were cross-referred to other programs in the grocery stores, and they were excited to have the services brought to them at the grocery stores. For example, account #4 noted, "We have also had an opportunity to cross-refer shoppers to each other and reemphasize health information offered by the teams." Also, account #5 reported, "When we provide them with their health screening results, they often want to take action by approaching the other coalition partners to receive more information." These two examples show how shoppers were motivated by the services being offered simultaneously at one location. The example from account #5 demonstrates that the shoppers found one-stop services accessible and helpful.

6. Culture, and Language – Bilingual

Linguistic and cultural skills of bilingual professionals improve program delivery and increase acceptability of the services offered (Mitchell, Malak, & Small, 1998). The majority of coalition members are bilingual (Spanish and English) and culturally adept in the region; the importance of this was apparent in the accounts. For example, as account #5 wrote, “Language and cultural appropriateness could have been a barrier, but fortunately, many of our partners and participants are from a Latino/Hispanic background, and that is an asset.” The IPOC utilized this advantage to increase engagement, awareness of its programs, and dissemination of information in a culturally appropriate and acceptable manner. As evidenced, communicating in a local language, especially to communities having limited understanding of English, could help increase community trust and participation (Casado, Negi & Hong, 2012).

7. Lift in Sales

The evaluation also found that the coalition had some positive effects on the sales and purchases, especially on the food items displayed by the nutrition education team. For example, account #2 wrote, “In most cases, we see an increase in sales of items used in the recipe demonstrations, which is a good thing for our business too.” This quote demonstrates how the coalition presence in the grocery stores impacted purchasing of healthy food choices. In addition, account #4 noted, “They seem interested in learning more about recipes for healthier diets using low-cost foods.” These similar findings have been reported in other grocery interventions that have increased purchase and availability of healthful food among two low-income neighborhoods in places such as Philadelphia (Hillier et al., 2012).

Coalition Specific Challenges

1. Coordination and Conflicting Schedules and Timing

Several coalition partners reported lack of coordination as the major challenge experienced by the IPOC. Other coalition partners felt that change in leadership or personnel could be the reason for the insufficient coordination of some activities. For example, account #1 noted, "Greater coordination is needed, especially when changes within organizations, such as personnel, can deter progress somewhat." Also, account #4 indicated, "We did not get to offer the program in collaboration with some of the other organizations/programs that are part of the coalition." Other partners associated lack of coordination to understanding coalition's goal. For example, account #5 noted, "We need better coordination, regular communication among partners, and clear agreement on collective goals and shared outcome measures." The partners felt that the coalition members were focused on their programs more than implementing the coalition's agenda in a coordinated and synergistic manner, and that could be one of the areas for improvement.

Coalition Specific Recommendations

1. Internal Communication and Capacity Building

The IPOC members, however, had recommendations they thought if put in place could improve the coalition's effectiveness. For example, regarding improving internal communication, account #4 suggested, "I think some kind of guide that describes each coalition member's programs and how they are tied to the coalition would be very helpful." Also, account #1 noted, "Some practical suggestions for increasing coordination and impact are including the

recipe of the week in the store flier, better signage within the store directing shoppers to the coalition activities, and feedback to store managers regarding the numbers and types of customers engaged so they can better see the impact of the programming." Sharing knowledge and empowering coalitions builds capacity at multiple ecological levels (individual, organizational and societal level) which in turn improves delivery of services (Chaskin et al., 2001; Butterfoss, 2004).

2. Expansion of Services

Respondents also recommended increasing its services to other grocery stores. For example, account #1 recommended taking services to other stores, "There are many stores that are interested in hosting the coalition partners, so it is important that we find ways to expand our capacity." Account #4 also suggested the need for a marketing strategy to other organizations or agencies to increase partnerships and membership within the coalition. Finally, account #2 noted, "One thing that could be improved upon is to have better coordination between the demonstration recipe of the week and the displays we set up in the store to ensure ingredients for the recipe are prominently displayed so customers know how to find it."

3. Create a Leadership Position

As noted with coordination challenges, several coalition partners recommended a leadership position be created to lead the coalition in delivery of services in partnership with all stakeholders. For example, account #5 stated, "We need one centralized coordinating entity or partner who can lead communication with store managers and among coalition

partners." This leader could coordinate with store managers and organize schedules to ensure the coalition members deliver programming at the same time and location.

Location Specific Input

1. **Location and Outreach**

The location where a program is implemented may affect how a program will be received and, therefore, the impact on targeted behaviors. As described in the narratives, most of the coalition partners were motivated to join other partners in the grocery stores in order to increase the number of people reached. In fact, most partners reported that they increased the number clients enrolled in their program or using their services through grocery store outreach. For example, account #6 noted, "Compared to when we were implementing our program separately, the coalition has helped us reach a larger population and increase engagement." Grocery stores may be underutilized as sites to engage people for programming and outreach services. However, some coalition members reported challenges involved with the venue, including a lack of new recruits. For example, account #6 noted, "We noticed after a few weeks that we were seeing the same families and individuals at the store. Since we cannot have duplicated participants within our program, it became a challenge." Also, sometimes the shoppers could be in a rush and not get to attend all the services. For instance, account # 4 noted, "If people were not shopping in a rush, they would at least stop by our table to learn about our program."

2. **Space**

Space was also noted as a potential challenge. For example, account #6 stated, "Some store locations have limited space so offering outreach and services from all coalition members

at the same time is not feasible." Similarly, it could have been more effective for programs such as health screening and WIC to have private space. For example, as account #3 indicated, "Some shoppers were hesitant to talk to us because of what seemed to be a point of pride – they did not want to be associated with an assistance program."

Conclusion

As the CCAT describes, the coalition takes three phases: formation, maintenance, and institutionalization. The IPOC members described the process and operations of the coalition and some of the outcomes they have experienced while working as a coalition. The most frequently cited success in this maintenance phase was the coalition's positive partnership and collaboration. They also reported an increased number of people reached. Although, we cannot numerically quantify the impact of the IPOC, partners narratives suggest the coalition benefitted each program. Partners also reported some challenges especially with coordination of the coalition's activities. Based on these findings, establishment of a single leadership position or organization could drive the coalition into the sustainable institutionalization phase.

Regarding the SEM, the IPOC impacted individuals and families by the nature of the targeted outreach and programming. In addition, the coalition activities impacted each partnering organization as well as the stores within which the programming and outreach took place. With increased coordination and capacity building, IPOC may be able to have regional impact.

In conclusion, this qualitative analysis suggests IPOC is having its intended impact on individuals, families, and partnering organizations. By improving coordination through a strengthened leadership approach, capacity and impact can be enhanced. This will likely require a dedicated position within one of the partnering organizations. Future efforts may focus on establishing quantifiable methods to assess the impact of the coalition in increasing access to and selection of healthy food. Such quantitative data could bolster the justification for increased coalition expansion and continued support for individual partnering organizations. In addition, it would be beneficial to study shoppers' perspectives to gain insight into additional ways to enhance the impact of the coalition. These findings can be useful to organizations in other

communities who are considering similar coordinated efforts to improve delivery of programming and outreach.

MPH Core Competencies

A. Evidence-based Approaches to Public Health

2. Select quantitative and qualitative data collection methods appropriate for a given public health context

C. Planning & Management to Promote Health

11. Select methods to evaluate public health programs

D. Policy in Public Health

13. Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes

E. Leadership

16. Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making.

References

American Journal of Community Psychology. (2016). *AJCP New Opportunities*. Retrieved from https://www.scra27.org/publications/ajcp/ajcp-new-opportunities

American Lung Association. (2016). Cutting tobacco's rural roots: *Tobacco use in rural communities. 2012*. Retrieved from http://www. lung. org/assets/documents/publications/lung-disease-data/cutting-tobaccos-rural-roots. pdf.

Anderson-Carpenter, K. D., Watson-Thompson, J., Jones, M. D., & Chaney, L. (2017). Improving community readiness for change through coalition capacity building: Evidence from a multisite intervention. *Journal of community psychology*, *45*(4), 486-499.

Bandura, A. (2014). Social cognitive theory of moral thought and action. In *Handbook of moral behavior and development* (pp. 69-128). Psychology Press.

Balcázar, H. G., de Heer, H., Rosenthal, L., Duarte, M. O., Aguirre, M., Flores, L., ... & Schulz, L. O. (2010). Peer reviewed: a Promotores de Salud intervention to reduce cardiovascular disease risk in a high-risk Hispanic border population, 2005-2008. *Preventing chronic disease*, *7*(2).

Becker, M. H., Radius, S. M., Rosenstock, I. M., Drachman, R. H., Schuberth, K. C., & Teets, K. C. (1978). Compliance with a medical regimen for asthma: a test of the health belief model. *Public health reports*, *93*(3), 268.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open*, 2, 8-14.

Borjas, G. J. (2004). Food insecurity and public assistance. *Journal of Public Economics*, *88*(7-8), 1421-1443.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American psychologist, 32(7), 513.

Brown, L. D., Alter, T. R., Brown, L. G., Corbin, M. A., Flaherty-Craig, C., McPhail, L. G., ... & Weaver, M. E. (2013). Rural Embedded Assistants for Community Health (REACH) Network: first-person accounts in a community–university partnership. *American journal of community psychology*, *51*(1-2), 206-216.

Brown, L. D., Feinberg, M. E., & Greenberg, M. T. (2012). Measuring coalition functioning: refining constructs through factor analysis. *Health Education & Behavior*, *39*(4), 486-497.

Butterfoss, F. D. (2004). The coalition technical assistance and training framework: helping community coalitions help themselves. *Health Promotion Practice*, *5*(2), 118-126.

Butterfoss, F. D., Goodman, R. M., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health education research*, *8*(3), 315-330.

Butterfoss, F. D., & Kegler, M. C. (2009). The community coalition action theory. *Emerging theories in health promotion practice and research*, 2, 237-276.

Butterfoss, F. D., & Kegler, M. C. (2002). Toward a comprehensive understanding of community coalitions. *Emerging theories in health promotion practice and research*, 157-193.

Cardazone, G., Sy, A. U., Chik, I., & Corlew, L. K. (2014). Mapping one strong 'Ohana: Using network analysis and GIS to enhance the effectiveness of a statewide coalition to prevent child abuse and neglect. *American journal of community psychology*, *53*(3-4), 346-356.

Casado, B. L., Negi, N. J., & Hong, M. (2012). Culturally competent social work research: Methodological considerations for research with language minorities. Social Work, 57(1), 1-10.

Cawley, J., Sweeney, M. J., Sobal, J., Just, D. R., Kaiser, H. M., Schulze, W. D., ... & Wansink, B. (2015). The impact of a supermarket nutrition rating system on purchases of nutritious and less nutritious foods. *Public health nutrition*, *18*(1), 8-14.

Chaskin, R. J. (2001). Building community capacity: A definitional framework and case studies from a comprehensive community initiative. Urban affairs review, 36(3), 291-323.

Choi, S. K., Fram, M. S., & Frongillo, E. A. (2017). Very low food security in US households is predicted by complex patterns of health, economics, and service participation. *The Journal of nutrition*, *147*(10), 1992-2000.

Christaldi, J., & Cuy Castellanos, D. (2014). Identifying factors, barriers, and solutions related to food insecurity in Lackawanna county, Pennsylvania. *Journal of hunger & environmental nutrition*, *9*(2), 170-182.

Coleman-Jensen, A., Nord, M., Andrews, M., & Carlson, S. (2012). Household food security in the United States in 2011. USDA Economic Research Service, Economic Research Report Number 141.

Cummins, S., Flint, E., & Matthews, S. A. (2014). New neighborhood grocery store increased awareness of food access but did not alter dietary habits or obesity. Health affairs, 33(2), 283-291.

Cummins, S., Petticrew, M., Sparks, L., & Findlay, A. (2005). Large scale food retail interventions and diet.

Davis, E., Wojtanowski, A., Weiss, S., Foster, G., Karpyn, A., & Glanz, K. (2016). Employee and customer reactions to a healthy in-store marketing intervention in supermarkets. J Food Res, 5(1), 107-1113.

de Heer, H. D., Salinas, J., Lapeyrouse, L. M., Heyman, J., Morera, O. F., & Balcazar, H. G. (2013). Binational utilization and barriers to care among Mexican American border residents with diabetes. *Revista Panamericana de Salud Pública*, *34*, 147-154.

DiClemente, R. J., Crosby, R. A., & Kegler, M. C. (Eds.). (2009). *Emerging theories in health promotion practice and research*. John Wiley & Sons.

Dixon, L. B., Winkleby, M. A., & Radimer, K. L. (2001). Dietary intakes and serum nutrients differ between adults from food-insufficient and food-sufficient families: Third National Health and Nutrition Examination Survey, 1988–1994. *The Journal of nutrition*, *131*(4), 1232-1246.

Eggert, L. K., Blood-Siegfried, J., Champagne, M., Al-Jumaily, M., & Biederman, D. J. (2015). Coalition building for health: A community garden pilot project with apartment dwelling refugees. *Journal of community health nursing*, 32(3), 141-150.

Ferketich, A. K., Liber, A., Pennell, M., Nealy, D., Hammer, J., & Berman, M. (2010). Clean indoor air ordinance coverage in the Appalachian region of the United States. *American Journal of Public Health*, *100*(7), 1313-1318.

Feighery, E., & Rogers, T. (1990). Building and Maintaining Effective Coalitions. Palo Alto, CA: Health Promotion Resource Center. *Stanford Center for Research in Disease Prevention*.

Feinberg, M. E., Greenberg, M. T., Osgood, D. W. (2004a). Readiness, functioning, and perceived effectiveness of community prevention coalitions: A study of Communities That Care. *American Journal of Community Psychology*, 33, 163-176.

Food Marketing Institute. (2014). Supermarket facts. *Arlington, VA*.
Foster, G. D., Karpyn, A., Wojtanowski, A. C., Davis, E., Weiss, S., Brensinger, C., ... & Leuchten, D. (2014). Placement and promotion strategies to increase sales of healthier products in supermarkets in low-income, ethnically diverse neighborhoods: a randomized controlled trial. *The American journal of clinical nutrition*, *99*(6), 1359-1368.
Francisco, V. T., Paine, A. L., & Fawcett, S. B. (1993). A methodology for monitoring and evaluating community health coalitions. *Health Education Research*, *8*(3), 403-416.
Glanz, K., & Yaroch, A. L. (2004). Strategies for increasing fruit and vegetable intake in grocery stores and communities: policy, pricing, and environmental change. *Preventive medicine*, *39*, 75-80.
Glanz, K., Bader, M. D., & Iyer, S. (2012). Retail grocery store marketing strategies and obesity: an integrative review. *American journal of preventive medicine*, *42*(5), 503-512.
Goodman, R. M., Speers, M. A., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., ... & Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *health education & Behavior*, *25*(3), 258-278.
Gray, B. (1989). Collaborating: Finding common ground for multiparty problems.
Hasan-Ghomi, M., Ejtahed, H. S., Mirmiran, P., Hosseini-Esfahani, F., Sarbazi, N., Azizi, F., & Sadeghian, S. (2015). Relationship of food security with type 2 diabetes and its risk factors in Tehranian adults. *International journal of preventive medicine*, *6*.
Hays, C. E., Hays, S. P., DeVille, J. O., & Mulhall, P. F. (2000). Capacity for effectiveness: The relationship between coalition structure and community impact. *Evaluation and Program Planning*, *23*(3), 373-379.
Hernandez, D. C., Reesor, L. M., & Murillo, R. (2017). Food insecurity and adult overweight/obesity: gender and race/ethnic disparities. *Appetite*, *117*, 373-378.
Hill, B. G., Moloney, A. G., Mize, T., Himelick, T., & Guest, J. L. (2011). Prevalence and predictors of food insecurity in migrant farmworkers in Georgia. *American journal of public health*, *101*(5), 831-833.
Hillier, A., McLaughlin, J., Cannuscio, C. C., Chilton, M., Krasny, S., & Karpyn, A. (2012). The impact of WIC food package changes on access to healthful food in 2 low-income urban neighborhoods. *Journal of nutrition education and behavior*, *44*(3), 210-216.
Himmelman, A. T. (2001). On coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment. *American journal of community psychology*, *29*(2), 277-284.
Holben, D. H., & Pheley, A. M. (2006). Peer reviewed: diabetes risk and obesity in food-insecure households in rural Appalachian Ohio. *Preventing chronic disease*, *3*(3).
Holmes, A. S., Estabrooks, P. A., Davis, G. C., & Serrano, E. L. (2012). Effect of a grocery store intervention on sales of nutritious foods to youth and their families. *Journal of the Academy of Nutrition and Dietetics*, *112*(6), 897-901.
Jagosh, J., Bush, P. L., Salsberg, J., Macaulay, A. C., Greenhalgh, T., Wong, G., ... & Pluye, P. (2015). A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC public health*, *15*(1), 725.
Kaiser, L. (2008). Why do low-income women not use food stamps? Findings from the California Women's Health Survey. *Public health nutrition*, *11*(12), 1288-1295.
Keene Woods, N., Watson-Thompson, J., Schober, D. J., Markt, B., & Fawcett, S. (2014). An empirical case study of the effects of training and technical assistance on community coalition functioning and sustainability. *Health promotion practice*, 15(5), 739-749.

Kegler, M. C., Rigler, J., & Honeycutt, S. (2010). How does community context influence coalitions in the formation stage? A multiple case study based on the Community Coalition Action Theory. *BMC public health*, *10*(1), 90.
Kempe, A., Albright, K., O'Leary, S., Kolasa, M., Barnard, J., Kile, D., ... & Barrow, J. (2014). Effectiveness of primary care–public health collaborations in the delivery of influenza vaccine: a cluster-randomized pragmatic trial. *Preventive medicine*, 69, 110-116.
Lyn, R., Aytur, S., Davis, T. A., Eyler, A. A., Evenson, K. R., Chriqui, J. F., ... & Brownson, R. C. (2013). Policy, systems, and environmental approaches for obesity prevention: a framework to inform local and state action. Journal of public health management and practice: JPHMP, 19(3 Suppl 1), S23.
Lombe, M., Nebbitt, V., Yu, M., Reynolds, A., & Sinha, A. (2015). Examining food security among children participating in Supplemental Nutritional Assistance Program (SNAP): Implications for human rights. *Handbook for Poverty*.
Lombe, M., Yu, M., & Nebbitt, V. E. (2009). Assessing effects of food stamp program participation on child food security in vulnerable households: Do informal supports matter?. *Families in Society*, *90*(4), 353-358.
Maghsoudi, Z., & Azadbakht, L. (2012). How dietary patterns could have a role in prevention, progression, or management of diabetes mellitus? Review on the current evidence. *Journal of research in medical sciences: the official journal of Isfahan University of Medical Sciences*, *17*(7), 694.
Mancino, L., & Guthrie, J. (2014). *SNAP households must balance multiple priorities to achieve a healthful diet* (No. 1490-2016-128588).
Manikam, S., & Russell-Bennett, R. (2016). The social marketing theory-based (SMT) approach for designing interventions. *Journal of Social Marketing*, *6*(1), 18-40.
Manon M., Ramos A., Young C., Lang B., Whigham L., Redelfs A. & Gallinar J. (2017). Food for Every Child: Access and Demand for Healthy Food in the Paso del Norte Region. Philadelphia, PA: The Food Trust.
Markt, B., & Fawcett, S. (2014). An empirical case study of the effects of training and technical assistance on community coalition functioning and sustainability. *Health promotion practice*, *15*(5), 739-749.
Martin, S. L., Maines, D., Wigand, D., Martin, M. W., MacDonald, P. B., Andrade, M., ... & Polacsek, M. (2009). Peer Reviewed: Healthy Maine Partnerships: Policy and Environmental Changes. *Preventing chronic disease*, *6*(2).
Mattessich, P. W., & Rausch, E. J. (2014). Cross-sector collaboration to improve community health: a view of the current landscape. *Health Affairs*, 33(11), 1968-1974.
McCoy, M., Nordberg, A., Hoefer, R., & Mellinger, M. (2017). Strengthening Advocacy Coalitions: Lessons for Structure, Engagement, and Effectiveness from an IPV Coalition. *Journal of Social Service Research,* 43(4), 443-458.
Meenar, M. R. (2015). Nonprofit-driven community capacity-building efforts in community food systems. *Journal of agriculture, food systems, and community development*, *6*(1), 77-94
Mitchell, P., Malak, A., & Small, D. (1998). Bilingual professionals in community mental health services. *Australian & New Zealand Journal of Psychiatry*, 32(3), 424-433.
Monga, P., Keller, A., & Venters, H. (2014). Prevention and punishment: barriers to accessing health services for undocumented immigrants in the United States. *Laws*, *3*(1), 50-60.

Niederdeppe, J., Bu, Q. L., Borah, P., Kindig, D. A., & Robert, S. A. (2008). Message design strategies to raise public awareness of social determinants of health and population health disparities. *The Milbank Quarterly*, 86(3), 481-513.

Healthy Paso Del Norte. (2019a). Child Food Insecurity Rate. Retrieved from http://www.healthypasodelnorte.org/indicators/index/view?indicatorId=2108&localeId=2645&comparisonId=7227

Healthy Paso Del Norte. (2019b). Food Insecurity Rate. Retrieved from http://www.healthypasodelnorte.org/indicators/index/view?indicatorId=2107&localeId=2645&comparisonId=7227

Palomino, H., Peacher, D., Ko, E., Woodruff, S. I., & Watson, M. (2017). Barriers and challenges of cancer patients and their experience with patient navigators in the rural US/Mexico border region. *Journal of Cancer Education*, *32*(1), 112-118.

Pelto, D. J., Ocampo, A., Garduño-Ortega, O., López, C. T. B., Macaluso, F., Ramirez, J., ... & Gany, F. (2019). The Nutrition Benefits Participation Gap: Barriers to Uptake of SNAP and WIC Among Latinx American Immigrant Families. *Journal of community health*, 1-4.

Perry, A., Ettinger de Cuba, S., Cook, J., Frank, D. A., Meyers, A., Cutts, D., ... & Casey, P. (2007). Food Stamps as Medicine: A new perspective on children‘s health. *Children's Sentinel Nutrition Assessment Program*.

Powell, K. G., & Peterson, N. A. (2014). Pathways to effectiveness in substance abuse prevention: empowering organizational characteristics of community-based coalitions. Human Service Organizations: *Management, Leadership & Governance*, 38(5), 471-486.

Quandt, S. A., Arcury, T. A., Early, J., Tapia, J., & Davis, J. D. (2004). Household food security among migrant and seasonal Latino farmworkers in North Carolina. *Public Health Reports*, *119*(6), 568-576.

Rahwan, T., Michalak, T., & Wooldridge, M. (2014). A measure of synergy in coalitions. *arXiv preprint arXiv:1404.2954*.

Rezazadeh, A., Omidvar, N., Eini-Zinab, H., Ghazi-Tabatabaie, M., Majdzadeh, R., Ghavamzadeh, S., & Nouri-saeidlou, S. (2016). Food insecurity, socio-economic factors and weight status in two Iranian ethnic groups. *Ethnicity & health*, *21*(3), 233-250.

Rosenberg, M. (2017). Barriers to Accessing and Utilizing Preventative Healthcare for the US Hispanic Population.

Riggs, N. R., Nakawatase, M., & Pentz, M. A. (2008). Promoting community coalition functioning: Effects of Project STEP. *Prevention Science*, *9*(2), 63.Keene Woods, N., Watson-Thompson, J., Schober, D. J.,

Salinas, J. J., de Heer, H. D., Lapeyrouse, L. M., Heyman, J. M., & Balcázar, H. G. (2015). Insurance status is a greater barrier than income or acculturation to chronic disease screening in the Mexican origin population in El Paso, Texas. *Hisp Health Care Int*, *13*(4), 197-208.

Salinas, J., McCormick, J. B., Rentfro, A., Hanis, C., Hossain, M. M., & Fisher-Hoch, S. P. (2011). The missing men: high risk of disease in men of Mexican origin. *American journal of men's health*, *5*(4), 332-340.

Schoen, M. W., Moreland-Russell, S., Prewitt, K., & Carothers, B. J. (2014). Social network analysis of public health programs to measure partnership. *Social science & medicine*, 123, 90-95.

Sharma, M., & Smith, L. (2011). Community coalition action theory and its role in drug and alcohol abuse interventions. *Journal of Alcohol & Drug Education*, *55*(3), 3.

Shen, M., Gai, Y., & Feng, L. (2016). Limited access to healthcare among Hispanics in the US-Mexico border region. *American journal of health behavior*, *40*(5), 624-633.

Smythe-Leistico, K. J., Young, C. P., Mulvey, L. A., McCall, R. B., Petruska, M., Barone-Martin, C., ... & Coffee, B. A. (2012). Blending theory with practice: Implementing kindergarten transition using the interactive systems framework. *American journal of community psychology*, *50*(3-4), 357-369.

Song, H. J., Gittelsohn, J., Kim, M., Suratkar, S., Sharma, S., & Anliker, J. (2009). A corner store intervention in a low-income urban community is associated with increased availability and sales of some healthy foods. *Public health nutrition*, *12*(11), 2060-2067.

Spradling, P. R., Xing, J., Phippard, A., Fonseca-Ford, M., Montiel, S., Guzmán, N. L., ... & Kamili, S. (2013). Acute viral hepatitis in the United States–Mexico border region: Data from the Border Infectious Disease Surveillance (BIDS) project, 2000–2009. *Journal of immigrant and minority health*, *15*(2), 390-397.

Story, M., Kaphingst, K. M., Robinson-O'Brien, R., & Glanz, K. (2008). Creating healthy food and eating environments: policy and environmental approaches. *Annu. Rev. Public Health*, *29*, 253-272.

Truiett-Theodorson, R., Tuck, S., Bowie, J. V., Summers, A. C., & Kelber-Kaye, J. (2015). Building effective partnerships to improve birth outcomes by reducing obesity: The B'more Fit for healthy babies coalition of Baltimore. *Evaluation and program planning*, 51, 53-58

US Department of Agriculture Food and Nutrition Services. (2016). Women, Infants and Children (WIC): WIC eligibility requirements. Retrieved March 14, 2017, from https://www.fns.usda.gov/wic/wic-eligibility-requirements.

US Department of Agriculture Economic Research Service. (2019). Food security in the United States: Definitions of food insecurity. Retrieved from https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx

Van Hook, J., & Balistreri, K. S. (2006). Ineligible parents, eligible children: Food stamps receipt, allotments, and food insecurity among children of immigrants. *Social Science Research*, *35*(1), 228-251.

Walsh, L., Craddock, H., Gulley, K., Strauss-Riggs, K., & Schor, K. W. (2015). Building health care system capacity to respond to disasters: successes and challenges of disaster preparedness health care coalitions. *Prehospital and disaster medicine*, *30*(2), 112-122.

Watson-Thompson, J., Woods, N. K., Schober, D. J., & Schultz, J. A. (2014). Implementing the capacity building for change model with substance abuse prevention coalitions. *Journal of Community Psychology*, *42*(6), 748-763.

Weaver, L. J., & Fasel, C. B. (2018). A systematic review of the literature on the relationships between chronic diseases and food insecurity. *J Nutr Food Sci*, *9*(05), 519.

Wright, W. F., & Pritt, B. S. (2012). Update: The diagnosis and management of dengue virus infection in North America. *Diagnostic microbiology and infectious disease*, *73*(3), 215-220.

Wolff, T. (2010). *The power of collaborative solutions: Six principles and effective tools for building healthy communities.* San Francisco, CA: Jossey-Bass.

Wolfson, J. A., Ramsing, R., Richardson, C. R., & Palmer, A. (2019). Barriers to healthy food access: Associations with household income and cooking behavior. *Preventive medicine reports*, *13*, 298-305.

Young, C. R., Aquilante, J. L., Solomon, S., Colby, L., Kawinzi, M. A., Uy, N., & Mallya, G. (2013). Improving fruit and vegetable consumption among low-income customers at farmers markets: Philly Food Bucks, Philadelphia, Pennsylvania, 2011. *Preventing chronic disease*, *10*.

Young, C. R., Aquilante, J. L., Solomon, S., Colby, L., Kawinzi, M. A., Uy, N., & Mallya, G. (2013). Improving fruit and vegetable consumption among low-income customers at farmers markets: Philly Food Bucks, Philadelphia, Pennsylvania, 2011. *Preventing chronic disease*, *10*.

Yu, M., Lombe, M., & Nebbitt, V. E. (2010). Food stamp program participation, informal supports, household food security and child food security: A comparison of African American and Caucasian households in poverty. *Children and Youth Services Review*, *32*(5), 767-773.

Appendix

First-Person Account of Stakeholders' and Interview Guide/Prompts

You have been asked to deeply reflect on lessons learned and perspectives of the In-Store Coalition collaborative effort.
Here are some questions or prompts to get you started. We will follow-up with you on phone and /or in person to discuss your response in more detail (and complete any unanswered questions).

Participants who deliver in-store interventions will be provided with reflection prompts such as:

- Why did you decide to participate in the in-store coalition?
- What has been the biggest advantage to participating in this coalition?
- How has the coalition impacted your program? (Probe: goals, knowledge, capacity, technical assistance, etc.)
- What is different when you implement your program separately from the coalition compared to in coordination with the coalition?
- Narrate or give your personal experiences with clients/customers and how they received the in-store coalition program?
- How effective has the coalition been? Include some examples where possible
- Do you consider the in-store coalition a success? Why and/or why not?
- What are some of the challenges you have experienced in the in-store coalition?
- What are some of the barriers you might have witnessed with shoppers e.g. stigma, discrimination, cultural issues etc.?
- What could have been done better?
- Do you have any recommendations for this coalition?
- What else should we know about the impact of this coalition?

Coalition members who are store owners:

- How has the in-store program delivery by coalition members impacted your customers?
- How has the in-store program delivery by coalition members impacted your business?
- What are some of the challenges you have experienced in the in-store coalition?
- What could have been done better?
- Do you have any recommendations for this coalition?
- What else should we know about the impact of this coalition?

Vita

Dennis Nyachoti is a final year master's Public Health (MPH) student at the University of Texas, El Paso (UTEP). Recently accepted for a Doctor of Public Health program at the University of Texas School of Public Health at Houston. Before joining UTEP, he graduated from the Jomo Kenyatta University of Agriculture and Technology in Kenya with a bachelor's degree in Public Health. Nyachoti has over six (6) years' experience working in various community health programs both in the US-Mexico borderland and in Kenya.

Nyachoti has worked both in the non-profit and public sector in improving community health and prevention of injury and illness. For instance, he worked with the city of El Paso Public Health department in the emergency preparedness program as a preparedness assistant helping with the national stockpile program and COVID-19 education task force. Nyachoti has also been a teaching assistant in three undergraduate courses at UTEP (program evaluation, occupation health, and death, dying, and bereavement courses). He has also served as a research assistant in the Paso del Norte Institute for Healthy Living at college of health sciences, UTEP supporting in food insecurity and obesity research and evaluation programs.

Back in Kenya, Nyachoti led and participated in various disease prevention programs and epidemic responses with national and international organizations such as the African Medical Research Foundation (AMREF), Kenya Red Cross society and county government of Nairobi public health department. His research interests include program evaluation, epidemic response, food insecurity, and public health emergency preparedness and response.